

**Marriage, Sex and Reproduction: Manifestations of early marriage
in the lives of young women in Shivgarh, India.**



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In the partial fulfilment for the award of an MPhil in International Community Health at the
Institute of General Practice and Community Medicine, Section for International Health

UNIVERSITY of OSLO

May, 2009

Acknowledgements

I dedicate this piece of work to everyone who participated in this study. First and foremost, I would like to extend my gratitude to all of the women of Shivgarh who opened their homes to me and shared their stories with me. I would also like to thank the community health workers who gave me their valuable time despite being over-worked. Thank you all for letting me follow you in your work and thank you for letting me ask you questions about your work. Without you, this study would not have existed.

To Prof. Sverre Lie, thank you for inspiring me to go to India and work with something very close to heart. Thank you for your guidance, patience, kind words and for visiting me in India. Your help throughout this process has meant a lot to me.

To Prof. Johanne Sundby, thank you for supporting me and guiding me throughout this study. Thank you for challenging my assumptions and in helping me plan, structure and write this study. Thank you for having confidence in my abilities and for providing timely feedback to all my requests.

To Dr. Bernadette Kumar, thank you for always being there for me and thank you for guiding me. Without your help, encouragement and enthusiasm, this study would have been very difficult to carry out. Thank you for all your valuable comments, for making my stay in India colourful and interesting and thank you for introducing me to many interesting individuals. I am grateful.

To Dr. Vishwajeet Kumar, Aarti Kumar and the entire Saksham team, thank you for taking time out of your demanding schedule to guide and supervise me. Thank you for allowing me to conduct my study within your research projects, and thank you for allowing me to participate in staff meetings and in making me feel like one of the team.

To Nivedita, thank you for going the extra mile in helping me meet young married women and health workers in Shivgarh, and for being my friend throughout the fieldwork. Your valuable support as a research assistant gave me newer ideas that we both developed on, and most of which we also used in our interactions with young married women and community health workers. Thank you so much, Nivedita. You were a great sport!

To Save the Children Norway, for providing me with travel grant. Thank you for funding me with my project.

To Centre for the Development and the Environment – Thank you for providing me with a reading space on their campus.

To the Norway India Partnership Initiative for funding my fieldwork research in Shivgarh; I am very grateful.

To Mrs. Naheed Varma for being my host-mother in Uttar Pradesh, and for making my stay in India both pleasant and memorable. Thank you for opening your house and heart to me and for always welcoming me with a huge smile.

To my friends and flatmates in India, Ms. Devon C. Lee, Ms. Jane Menon, Mr. Badis Bensid and Mr. David Farris, thank you guys for being my friends and family in India, for making my trip to India the best trip ever, and for staying up with me at night working, for giving me feedback on my work, for providing entertainment in my life. Thank you David for listening to my endless thoughts on this project and for reciting colourful poetry to me. Thank you Jane for your kind words and for supporting me in what I believe in and do. Thank you Devon for making me laugh, for being the best of friends and for travelling to far off places with me, you ROCK! Thank you Badis for being you, for walking with me every step of the way and for making me realise what is important in life. I would not be without you all.

To you George, for being my friend, for believing in me, and for making me think that I can do whatever I set my mind on doing. I look forward to our years at Cambridge and for making me chase my dreams even when I was in India, far away from home.

To all my classmates, thank you for making the past two years enjoyable. A special thank you to Nina, Steve, Hildegunn and Kaja for sitting and writing with me. Thank you Mai, Dumo and Mekdes for always smiling and for lighting up the environment.

Thank you, Viva C. Thorsen and Heather Ames for your friendships, for reading my thesis and helping me sort out my thoughts. I am grateful for all your help.

To you mummy, thank you for always being there for me. If it were not for your endless support, I would not be where I am today. I am grateful that you are my mother for you have made me the person I am, for you have supported me in all my decisions-whether good or bad.

And finally, a special thanks to the love of my life, my boyfriend, Erlend. Thank you, darling, for being my pillar of strength, for providing me with critical feedback, for being understanding and for being patient. Thank you for encouraging me and believing in me. Thank you for staying up all night listening to my problems when I was in India and thank for walking with me through life. Without you, I would not have been able to finish this.

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Abstract

Title: Marriage, Sex and Reproduction: Manifestations of early marriage in the lives of young women in Shivgarh, India.

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Introduction:

Early marriage is both socially and culturally accepted in Shivgarh, a rural area of Uttar Pradesh, India. About 61.1% of all rural women residing in this province are married before they reach the age of eighteen years. Uttar Pradesh also scores lower on consecutive social and health development indicators, making it one of the poorest states in India.

Overall Objective:

The proposed study aims to gain a deeper understanding of the context of early marriage and sexual and reproductive health issues in Shivgarh.

Specific Objectives were to:

- Explore the reasons for the existence of early marriage in Shivgarh;
- Describe young married women's perspectives on their married lives;
- Explore the context within which sexual and reproductive health decisions are made;
- Explore the nature of sexual and reproductive health services available to, and accessed by young married women.

Study Design and Methods:

Qualitative methods of interviews and non-participant observations were employed.

Findings:

Two main reasons were given for the existence of early marriage – poverty that leads to early marriage, and cultural factors that favour this practice. Being an ideal wife was important to all young married women and sex acted as a function of continued financial support from their spouses, and was important for their self-worth related to conceiving. Mother-in-laws and husbands played a major role in influencing decisions related to sexual and reproductive health, and women exercised very little self-autonomy on their bodies in this respect. Family planning services were available to women but not appropriate as the health workers showed a preference for tubal sterilisation. This preference was a result of their being monetary incentive related to money per sterilised woman for the health worker. Young women did not think that money incentive to deliver at hospitals was relevant as long as there were no skilled health workers present in the hospitals, and as long as they did not feel that they were being treated well. Thus, the sexual and reproductive health services were available but not always appropriate.

1. Prologue

Radha¹ is a 15 year old, illiterate adolescent bride who lives in a remote village in Uttar Pradesh. She is the youngest of three female siblings, who all got married before completing secondary school.

When their mother died some nine years ago, Radha's sisters were taken out of school to take care of the household. Radha's father works as a men's hairdresser in the local village and does not own any land. As Radha's mother also worked, they could afford sending their children to school. However, when she died, it became extremely difficult for Radha's father to manage on his own and he could no longer afford schooling his children. In hope for a better future for his daughters, he decided to marry off his girls. At that time, a lot of suitors would come by to see Radha's sisters, and one by one, they all got married. Radha never went to school. She learned how to become a good housewife, however. *"We had to do what our father wanted us to do. My sisters and I did not really have a choice. We are poor. Poor people do not have choices."*

Radha tells me that her sisters wanted to work so that they could support their father but he did not think that it was appropriate for an unmarried girl to go outside the house and work. *"People will start talking. They will say that I am not man enough to sort my own family out. That will not look good", he would say.*

Two years ago, when Radha started menstruating, she was introduced to the son of a local villager who works as a labourer on a contract basis. He is the youngest of three sons and both his brothers are married. Ramesh² is nearly 18 years old. Radha did not initially want to get married to this man because she had started fancying the neighbour's son. She tells me that she could not disappoint her father and decided to agree to go through with the wedding.

"I felt that I had to do what my father told me to do. I did not want to disappoint him but I cannot say that I was happy. I did not know who this person was or what he would be like but I guess one has all life to learn all this".

¹ The name has been changed.

² The name has been changed.

She tells me that she feels lonely in this household because none of her sister-in-laws talk to her. This is because Radha still has not produced a baby and is considered the black sheep of the family. *“You know they tell me that I do not want a baby, that I am not faithful. They tell me that if I do not produce a baby soon, it will look really bad for the entire family”.*

When talking about sex, she looks down on the ground and starts crying. *“Didi³, how should I tell you, he wants it three times a week. When I refuse, he beats me and forces me. I guess I do not have a choice”.* Radha tells me that it is painful and that she just wants a child so that she does not have to go through with the sex again. Whispering, she tells me that she feels pressurised into having a baby, that her mother-in-law tells her that she needs to prove her worth.

Radha has always dreamt of being one of the girls on the film posters. She tells me that she has always wondered how they look so beautiful and happy. She tells me that she is sure that they do not need to think about having babies and pleasing others. Radha tells me that people who have both their parents who support them through life are lucky because they can attend school and enjoy life. She wonders if life had been different if she had an opportunity to work instead of getting married.

“Maybe, didi, one day God will listen to my prayers and I will be lucky too. Maybe one day I will be able to give birth to a child and my mother-in-law will start liking me”.

³ Didi- the Hindi word for sister

2. Introduction

It is 5.00 am in the height of summer in Shivgarh, and Krishna⁴ is just getting ready to start her daily chores. This morning, she is going to make cow dung cakes, clean the house, make food for her family of ten, and help her husband in the betel fields. In her book on Indian culture, Henderson writes that the hard life of a rural Indian woman is proverbial, that this woman's voice echoes in the air from the break of dawn till past midnight. This woman is the first in her family to get up and the last to go to bed (1). Krishna is one such rural Indian woman. This portrait of a rural Indian woman is the one of a woman who is hard-working and steadfast on the one hand, and vulnerable and socially oppressed on the other.

Henderson's rural Indian woman is someone who is poor and less likely to attend school (2;3), more likely to marry early (3-8), more likely to be underweight (8), more likely to die or get ill during childbirth (9;10), less likely to exert control over her own body (11), and less likely to make sexual and reproductive health decisions on her own (5). She also comes from a country where the paradox of being a woman is quite palpable – on the one side, India is one of the few nations where women have been heads of state and reached the Moon; it is, however, also a country where female foeticide, child marriage, ban on widow remarriage, and burning of women are socially acceptable (1).

This thesis is about eight such young Indian women, who live in Shivgarh, a rural area in Uttar Pradesh, India. They got married either before or immediately after having reached the age of menarche. It is an enquiry into why the practice of adolescent marriage still exists in this culture despite being illegal; it is about what it means for these young married women to be sexually active; it is about the context within which sexual health decisions are made; and what types of sexual and reproductive health services are accessed by, and available to young these eight women through the National Rural Health Mission, India. I also present accounts from eight community health workers who work in the areas where these women live in an attempt to illustrate how they address these women's sexual health needs and how they influence them. Thus, the overall aim of this study is to get a broader understanding of the sexual and reproductive health of young married women residing in rural India.

⁴ Krishna is one of the eight young married women who participated in this study; her name has been changed.

2.1 India- A Demographic and Health Profile

2.1.1 Background

India or *Bharat* is a culturally and geographically diverse country. It is divided into 29 states and seven union territories. The history of Modern India dates back to August 15, 1947, when India gained its independence from the British.

2.1.2 Economy

Post independence, the Nehru⁵ government proposed a policy of planned economic development⁶, which was pursued until mid 1980s. Planned economic development was characterised by extensive regulation, protectionism and public ownership, which resulted in slow growth (12). As these attempts did not resolve India's poverty crisis, as it had been anticipated by the Nehru government, the Indian government shifted towards economic liberalisation policies in early 1990s making the economy a market-based economy (12). Indian economy has become the twelfth largest economy in the world and has grown by 9.6% by the end of 2008 (13), making it the second fastest economy after China to have grown extensively the recent years.

However, agriculture is still the predominant occupation in India, and accounts for approximately 60% of the employment force (14) but only accounts for about 17% of the GDP. The service sector makes up approximately 28% and the industrial sector about 12% of the employment force accounting for 54% and 29% of the GDP. This is interesting as it increases the urban-rural divide in India, as agriculture is the main occupation in rural areas (14). Albeit an increase in the overall economy is a step in the right direction out of poverty for a fraction of Indians, majority of Indians have not benefited from an economic boost. The World Bank's India Profile shows that about 28 and 26 per cent of Indians living in rural and

⁵ Jawaharlal Nehru was the first Prime Minister of India.

⁶ Planned Economic Development: A plan economy initiative set up by the first elected Prime Minister, Nehru, to tackle poverty. It included five major steps: 1. Drawing five year economic plans; 2. Assessing the material, capital and human resources; 3. Determining areas of resource allocation; 4. Appraising the economic progress of the country; and 5. Advising the government on economic policies and programmes.

urban areas still live below poverty line (15). This thesis will be concerned with Indians living in rural India, who belong to these 28% of Indians living below the poverty line.

2.1.3 Demographics

1. Population

India, post partition, is the seventh largest country by geographical area, and the largest democracy in the world. It is also the second most populous country in the world with a population of nearly 1.14 billion. This means that 17.2% of the world's total population lives in India. The US Department of Commerce suggests that India adds to more people to the world's population than any other country in the world as of 1997 (16). India is a young nation with 65% of its population between the ages of 15 and 64, and approximately 32% of its population between the ages of 5 and 15 (17). Although India is experiencing migration from rural to urban areas, 71% of Indian population still resides in rural areas (14).

1.2 Urban- Rural Divide in Population

This concept is of direct relevance to this study as the individuals interviewed in this study reside in rural India. Rural-urban divide in India is prevalent on a number of levels, and is best illustrated by the table below. The data presented are from the National Family Health Survey (NFHS)-III, which is the third series of a large-scale survey conducted in a representative sample of households throughout India (14).

The table below illustrates that individuals residing in rural India are more likely to lack the basic amenities of electricity, piped drinking water, and toilet facilities. Out of India's 1.14 billion people, 32.4% of the individuals above the age of 6 are illiterate. 61.3% of these live in rural India. The Registrar-General of India states that rates of illiteracy are higher among girls and women residing in rural areas in comparison with boys and men from rural areas (18). Further, these figures are higher in families with higher number of females. Rural women are less likely to have institutional deliveries than their urban counterparts. Rural parents are also less likely to vaccinate their children than urban parents.

[Table I: Demographic differences – Urban vs. Rural India](#)

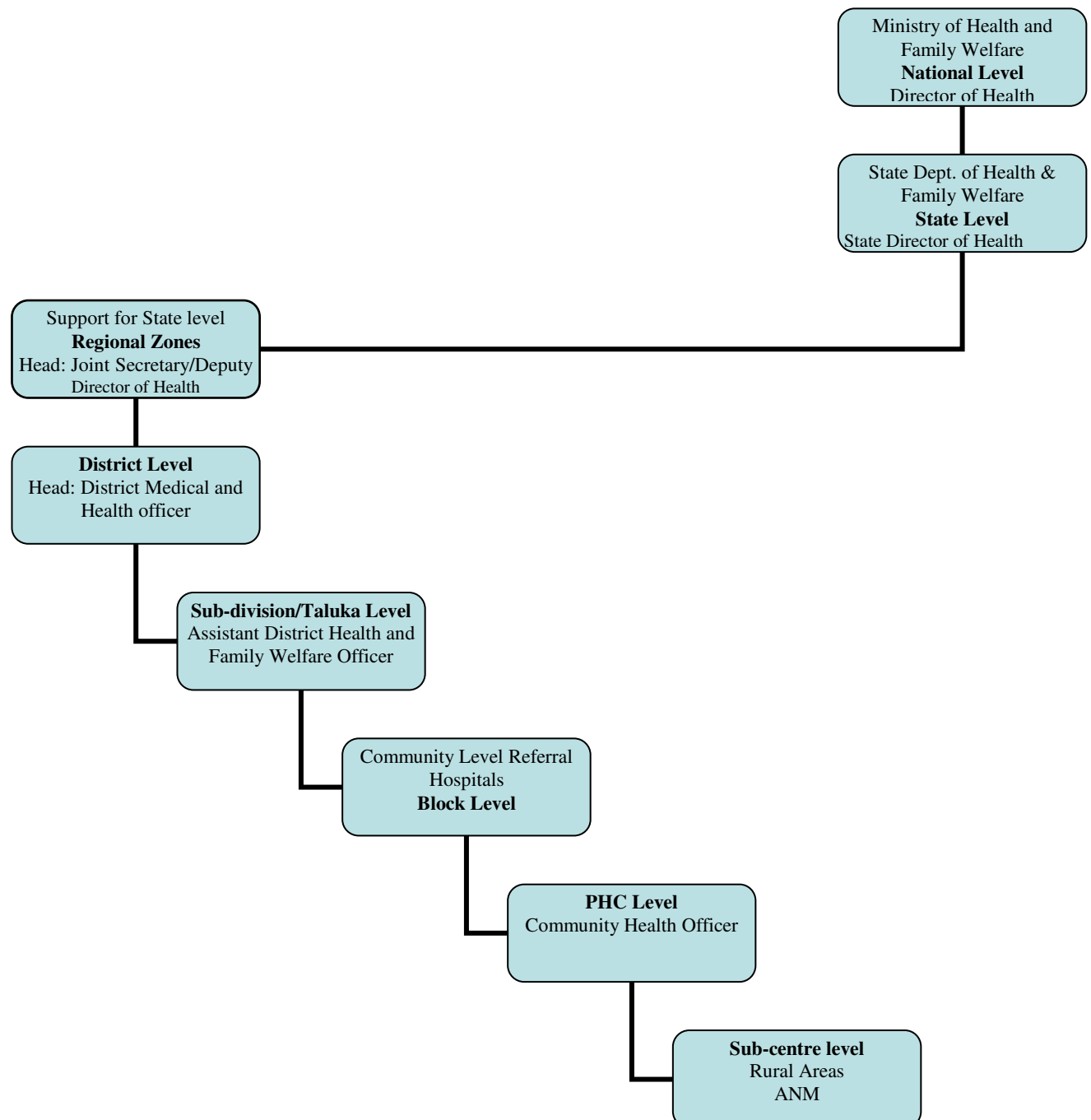
NFHS-III Questions	Urban population	Rural population	India Overall
% of households that have electricity	93.1%	55.7%	67.9%
% of households that have piped drinking water	71.0%	27.9%	42.0%
% of population aged 6+ that is literate	81.0%	61.3%	67.6%
% of population that lives in built houses	74.1%	25.5%	41.4%
% of population that has access to a toilet facility	83.1%	25.9%	44.5%
Trends in institutional deliveries (last three years)	69.0%	31.0%	41.0%
12-23 months old children who have received all recommended vaccines	61.0%	37.0%	44.0%
Trends in Infant Mortality; Number of Infant Deaths per 1,000 live births	42	62	57
% of 15- 49 year olds with regular exposure to media (TV, radio or newspaper at least once a week)	Men: 93% Women: 87%	Men: 73% Women: 54%	Men: 80% Women: 65%

This table suggests that living in rural India is, statistically, more difficult due to lack of basic amenities. The following section deals with the way Indian healthcare system is organised.

2.1.4 Organisation of the Health System in India

India has two different types of health systems – private and public. This thesis will only be concerned with the public health system, which extends from national to village level. The diagram below represents the rough organisation of India's health system:

[Figure I: Health System in India](#)



The figure above illustrates the extensive organisation of India's health system. This thesis is concerned with the lowest level of health services, that is, the healthcare that is organised at the sub-centre and primary healthcare levels. These two levels of healthcare dominate the public health landscape of rural India. A community health officer, which in most cases is a general practitioner, is the head of the primary healthcare centre. However, it is the sub-centres that play the most important role in establishing contact between community members and the PHCs. These sub-centres are led by auxiliary nurse-midwife, an outreach worker, who works with a population of 5,000 individuals and is assisted by 5 Accredited Social Health Activists, ASHA, who work with a population of 1,000 individuals each. This means that ASHA are the first point of contact for each patient, and the first referral is almost always made to the ANM (19). Sub-centres and primary healthcare centres operate under the umbrella organisation, the National Rural Health Mission (NRHM), which is a combination of national programmes, such as the Reproductive and Child Health II Project, the National Disease Control Programmes, and the Integrated Disease Surveillance Project. This means that the ASHA and ANM are responsible for interventions on the grassroots level. The NRHM workers collaborate with the Anganwadi workers, who are employed by the Department of Women and Child Welfare, Ministry of Education, India. The AWW and ASHA have overlapping roles as both of them are supposed to work on reproductive health and immunisation of children (19).

The health workers presented in this thesis are these two community health workers, the ASHA and AWW, who work on the grassroots level in villages in Uttar Pradesh.

2.2 Young People – The Subjects of this Study

2.2.1 Who are they and where do they live?

The World Health Organisation defines ‘adolescence’ as a period between the ages of 10 and 19 years, and ‘youth’ as a period between the ages of 15 and 24 years (20). Sundby argues that this terminology is not entirely neutral, and that one should use the term ‘young people’ (individuals aged between 10 and 24 years) instead of adolescents to ensure neutrality. The term ‘young people’ clarifies that these individuals are ordinary people who are young and not a ‘different alien species’ (21). Thus, I will use the term ‘young people’ to refer to individuals between the ages of 15 and 19 for the purpose of this thesis.

It is estimated that half of the world’s population today is under the age of twenty five years, and approximately 1.2 billion out of these are between the ages of ten and nineteen years (22). The Population Reference Bureau estimates that about 80% of the world’s population lives in developing nations, and about two-thirds of these individuals live in rural areas (17). About 17.2% of the world’s entire population lives in India. It is not only the second most populous country but also a young population with 32% of its population being under the age of 15 years and about 63% of its population between the ages of 15 and 65 years (17). According to the United Nations Population estimates, about 21% of individuals living in India are between the ages of 10 and 19 years, and 10% of these are between the ages of 15 and 19 years (23). These figures suggest that a considerable amount of world’s young people live in India.

2.2.2 Young People – Transition from childhood to adulthood

Bott and Jejeebhoy underline that ‘adolescence’ as a cultural construct can be understood as a transition from childhood to adulthood, a period where young people experience changes due to puberty but may not assume the roles, privileges and responsibilities of adulthood (24). Sundby suggests that this transitional period is a vulnerable period for a young person because the young person herself or people around her may believe that she is ‘older than she is’, and may for instance, attempt to make a move towards sexual experimentation (21).

It is precisely this transition that is understood differently across cultural borders, and it is in this period that cultures differ in their notions of adulthood, sexual maturation and

marriageability. Bott et al. suggest that the nature of this transition may also vary tremendously by age, class and region (24). For instance, in certain cultures a 16 year old could be classified as an adult, whereas in other cultures, one is still a child at the age of 18. However, there is a general consensus that this transition involves gradual biological pubertal development as well as gradual sexual maturation (21). Van Look suggests that this transition should be considered a phase rather than a fixed age group, with physical, psychological, social and cultural dimensions, that are perceived differently by different cultures (25). It is precisely this phase that interests me as a researcher, and how in cultures where early marriage in young age is common, young men and women tend to 'skip' this transitional phase and enter adulthood sooner than in other cultures. Bott et al. suggest that this skipping of adolescence pushes young people into shouldering responsibilities for which they may not be fully equipped (24).

Thus, I have chosen to explore further this notion of skipping one's adolescence and entering directly into adulthood as a result of early marriage. My subjects reside in rural India, where the practice of early marriage has been accepted since middle ages but was legally abandoned in 1929, when the Child Marriage Restraint Act was passed (26). The reason why I have chosen to study India and not other countries is because India, being the second most populous country in the world, contributes to the largest absolute numbers of adolescents. Thus, this phenomenon affects more people in India than anywhere else in the world in absolute numbers.

In her review on adolescent sexual and reproductive behaviour in India, Jejeebhoy notes that the transition from childhood to adulthood among Indian females has traditionally tended to be sudden (27). She points out that although the onset of puberty may be delayed due to poor nutritional statuses; marriage and the onset of early sexual activity, pregnancy and childbearing occurs relatively early, thrusting young girls into early adulthood (27). The next section discusses why early marriage is a public health concern, and what impact it has on the lives of young individuals in this transitional phase. This study only focuses on girls in this transitional phase because early marriage globally is seen to affect the lives of females much more so than men with about 95% of those marrying early being women (28).

2.3 Early Marriage and Young People

2.3.1 What is Early Marriage?

The social institution of early marriage is considered to be one of the most persistent forms of sanctioned abuse of young people in the developing world. It is commonly referred to as the ‘socially licensed sexual abuse and exploitation of the child’(4). The UN Convention on the Rights of the Child (CRC) marks the age of 18 years being the dividing line between childhood and adulthood (29), and early marriage is defined as ‘any marriage carried out below the age of 18 years, before the girl is physically, physiologically, and psychologically ready to shoulder the responsibilities of marriage and childbearing (4;30).

It is suggested that early marriage remains a widely ignored violation of the health and development of girls and young women (31). Sagade outlines that although countries have legal frameworks prohibiting early marriage, governments are unable to enforce existing laws due to the ‘official tolerance of cultural, societal and customary norms that shape and govern the institution of marriage and family life’ (32).

According to the Article 16 of Universal Declaration of Human Rights, men and women of ‘full age’, that is, legally mature, have the right to marry and found a family. Marriage should be a formalised, binding partnership between two consenting adults (33). Early marriage, however, may take place without any formal registration, and without the consent of one or both parties involved in marriage. Haberland et al. suggest that in contexts where girls and women have limited say in decision-making in general, and where marriage is universally arranged by parents, a girl or young woman may have little choice to disagree when parents have already agreed (34). They suggest that this consent is not a willing agreement but can be characterised as a form of submission or ‘habitual acquiescence’ than genuine consent. Thus, early marriage is a type of marriage which may be illegal in the eyes of law but allowed due to customary laws and social norms that tolerate such practices.

2.3.2 Is early marriage a cause for concern?

MacIntyre writes that marriage is often regarded as a place of safety from the dangers and risks of being young (6). Globally, the United Nations Population Fund estimates that on average about five per cent boys and anything between forty and sixty five per cent of girls are married before reaching the age of sexual maturation (28). Although early marriage is a worldwide phenomenon, it is most common in the rural areas of Africa and South Asia (28). Global estimates indicate that anything between eighty to hundred per cent of young girls in Niger, Chad, Mali, Nigeria, Cameroon and Central African Republic, and anything between sixty and eight per cent of young girls in India, Tanzania, Mozambique, Madagascar, Kenya and Zambia are married before they reach the age of eighteen years (28). This is, therefore, considered as being the legal sexual age of maturation, unless the legal framework within a country permits its citizens to marry earlier or later.

Haberland et al. underline that rather than being a simple change in status from being unmarried to getting married, this transition changes virtually all the known and safe parameter's of a girl's life (34). As early marriage affects more women than men, this discussion will follow how early marriage is a cause of concern for young women's health. A plethora of research body indicates that the practice of early marriage thrives on poverty, and poses a great threat to the physical, developmental and psychosocial well-being of a girl child (2-6;8;9;20;27;35-37). Additionally, young girls are more likely to be married to older men, become widows at a younger age as a result, be more susceptible to domestic violence and die or contract complications during child labour than their older counterparts (27;32;34;38).

In his analysis on the early marriage, MacIntyre suggests that the ill-effects of early marriage have a direct bearing for six of the eight Millennium Development Goals, which are goals that aim to enhance the quality of life for peoples around the world (6). The Millennium Development Goal I seeks to eradicate extreme poverty and hunger. MacIntyre notes that young brides are less likely to have the training and opportunity to earn, and less likely to access resources. Singh et al. and Otoo-Oyortey et al. suggest that poverty is an underlying factor for why girls get married (off) earlier because they are seen as an economic burden on their families, and parents marry off their girls in order to get rid of this burden (2;3).

Early marriage also restricts a girl's access to education as young girls are often taken out of school either to get married or because their parents do not see the need for sending girls to school. Studies on the relationship between poverty and early marriage illustrate that in countries where parents have to pay dowry, they tend to marry off their girls earlier as young brides have to pay less dowry (2;3). The Millennium Development II is an ambitious goal that aims to achieve universal primary education by 2015. Bott et al. show that although education is on the rise and more girls today are enrolled in schools than ever before, it is the poorer sections of society that still do not have access to education (24). Early marriage, therefore, poses a threat to this goal as well.

Jejeebhoy notes that women's autonomy, that is, a woman's ability to possess control over her own body and her ability to make decisions related to self, are seriously at risk within the domain of early marriage (11;27). She suggests that early marriage is a product of patriarchal societies that discriminate against women both in the public and private sphere. In her study, she shows that all decisions are either made by the husbands or husbands' families, and young brides' mobility and decision-making are very restricted. Thus, early marriage poses a direct threat also to the achievement of Millennium Development Goal III, which aims to promote gender equality and empower women. Early marriage, therefore, leads to discrimination and disempowerment of a woman and her body (11).

Early marriages are often related to early childbirth, where women often are forced into having children earlier not only due to lack of knowledge regarding contraceptives but also because of lack of control over their bodies. Studies on early marriage and its outcomes show that due to physiological immaturity, adverse outcomes of pregnancy both for the mother and the child are more pronounced in young age (28). Furthermore, as women who engage in early marriages belong to the poorest sections of a society, they may not have access to appropriate healthcare services, which further endangers their health. This means that early marriage is also of relevance to the Millennium Development Goals IV and V that aim to reduce child mortality and improve maternal health respectively.

Due to lack of access to general as well as sexual education and lack of self autonomy, young married women may not have access to family planning services, making it very difficult for them to protect against sexually transmitted infections. Furthermore, young girls are also likely to marry older men, making them more susceptible to acquiring such infections (28).

Thus, the practice of early marriage may also pose a threat to the realisation of Millennium Development Goal VI that aims to combat HIV and AIDS, malaria and other diseases. Early marriage, therefore, is not only a public health concern but is also a violation of a girl's basic human rights. The social and economic dimensions of early marriage produce poorer women who are dependent on their husbands financially and discriminated against by the society. It is, therefore, worthy of attention and study as combating early marriage may help realise many of the millennium development goals as well as make the life situation of millions of young women better all over the world.

Studies from developed countries illustrate that an early investment in sexual and reproductive health as well as strengthening laws related to reproduction have led to an overall improvement in the health of women and their children, increased productivity in the general population, decreased fertility rates, and increased awareness regarding reproductive health issues (39). As early marriage is a function of sexual and reproductive health, solving this 'crisis' may help solve many health and development problems faced by developing countries, such as India.

2.3.3 Early marriage in India

As suggested above, anything between sixty and eighty per cent of girls are married before the age of eighteen in India. The National Family Health Survey-III suggests that nearly 61.1% of women residing in rural Uttar Pradesh were married by the time they turned 18 (14). The mean age of getting married, according to this nationwide demographic survey is 16 years of age for women. According to the Child Marriage Restraint Act of 1929, and the Prohibition of Child Marriage Act of 2006, early marriage is strictly forbidden (26). The legal age of marriage, according to these acts, is eighteen years for women and twenty-one for men, and no provision of relaxation is granted in the age of marriage or provision to marry either with the consent of parents or with special dispensation by the court before these ages (26;32). This means that the practice of early marriage is strictly forbidden under all circumstances and illegal. However, the punishment for engaging in this practice is very lenient in the sense that it results either in a small fine or imprisonment up to a maximum of three months. The marriage in itself is illegal but once performed, is both valid and legal. Therefore, the law does not serve a great purpose in protecting the lives of young girls and

boys. Furthermore, customary and religious laws of India allow this practice to prevail and no individuals have been charged, imprisoned or fined for having initiated this practice (26;32).

2.3.4 Uttar Pradesh – A case for early marriage

This study is concerned with the sexual and reproductive health of married adolescent girls aged between 15 and 19 residing in a rural setting in Uttar Pradesh, India. Uttar Pradesh is the largest and one of the poorest provinces in India with a population equivalent to that of Brazil's (approximately 190 million), a maternal mortality rate of approximately 517 per 100 000 live births, and about 25% of India's neonatal mortality (14). Further, U. P. is also one of the provinces where about 65% of girls are married before the age of 18 (14). However, this figure varies from urban to rural populations, where anything between 30- 40% of population is married before the age of 18 in cities and about 60- 70% in the villages. The National Family Health Survey- III, which is based on household data collected from about 230 000 individuals throughout India, suggests that about 14.3% of women are either already mothers or pregnant in urban U.P. at the time of survey (2005- 06) and about 16.3% in rural populations. However, one must read this numbers with caution as the NFHS- III only uses a subset of the total population. For instance, a community- based study from Shivgarh, U.P. (40) shows that about 30% of all women between the ages of 15 and 19 are married, figures that are grossly different from the NFHS- III.

The total fertility rate in U.P. is said to be 4.1, which is higher than the national average of 3.1, and considerably higher than the replacement figure of 2.1 as anticipated within the MDG framework (14). The National Family Health Survey- III also indicates that the uptake of antenatal care services are especially low in Uttar Pradesh, where only about 26.3% of all pregnant women have attended three antenatal care visits. This is slightly better in urban U.P. where about 40.9% of women attend the ANC clinics but as low as 22.6% in rural U.P. Similarly, most of the births (76.2%) in rural areas take place at home without the presence of a qualified health worker, and the prevalence of institutional deliveries is as low as 17.5% in rural areas and about 39.9% in urban areas.

Cross- national studies on sexual and reproductive health do not provide any data for the age of sexual initiation for adolescents in India but indicate that the mean average of marriage is

somewhat around sixteen years of age for girls, a figure that is compatible with the NFHS-III data for U.P. (24). Taking the above figures into consideration, one may assume that as a great proportion of 15- 19 years old are married in U.P., most of them also live in sexual relationships. Thus, the existence of early marriage in Uttar Pradesh is apparent.

2.3.5 Bio-medical literature on early marriage

A plethora of research body has outlined the biomedical consequences of early marriage and early childbirth. Studies concerning early pregnancy show a strong correlation between the age of the mother and maternal mortality (41). The adverse consequences of pregnancy are said to be more pronounced in this transitional period than in adulthood despite the fact that pregnancy in itself is a risk to female health nonetheless. It is suggested that girls aged between ten and fourteen are five times more likely and girls aged between fifteen and nineteen are twice as likely to die during pregnancy or child labour in comparison with young women aged between twenty and twenty four years(32). Having said this, it is not merely the age that determines mortality during pregnancy. A young girl who gets pregnant in a developed country with full access to health care facilities has just as great a chance to survive the outcomes of pregnancy as a young woman in her early twenties (42).

Lack of appropriate health services; lack of access to appropriate medication; lack of knowledge regarding safe pregnancy practices; anaemia, malnutrition, HIV and AIDS; unhygienic practices related with childbirth; poverty; unsafe abortions; and increased risk for preeclampsia, eclampsia, obstetric fistula and heavy bleeding are equally important factors leading to morbidity and mortality in adolescent pregnant girls (27;39). Due to the nature of female physiology and the fact that adolescent girls are disempowered within the context of child marriage, young girls are also more likely to acquire sexually transmitted infections (STI) due to an unmet need for contraception (41). Lack of awareness of the presence of STIs and lack of appropriate screening tools may also directly affect girls living in child marriages. In fact, it is estimated that nearly a quarter of a million adolescents become infected with sexually transmitted diseases on an every day basis, and more than half of new HIV- infections occur in young individuals (24). If left untreated, infections such as syphilis. may result in stillbirth, and maternal gonorrhoea may result in blindness in newborns (41).

2.3.6 Socio-medical literature on early marriage

As discussed above, biomedical aspects of early sexual initiation and pregnancy are well-defined and well-researched. Sociological studies concerning sexual and reproductive health in India and South Asia have mainly focused on attitudes towards marriage, knowledge of STIs within certain groups of adolescents, sexual debut, quality of care in health settings and sexual preference (24;27). Most of the studies concerned with the quality of care given to different age groups have been conducted in community hospitals either using individuals already registered for antenatal care programmes or those who primarily give birth at hospitals (43). Qualitative studies have mainly used student populations either from secondary schools or recruited first year university students from urban settings alone (27). Jejeebhoy notes that most of the studies concerned with sexual preference, the context of first sexual intercourse and sexual experience have either used magazine surveys rather than culturally validated interview guides (27). Bott et al. point out that very little is known regarding adolescents' ability to make informed sexual and reproductive choices (24). Qualitative studies looking at these aspects have used more boys in their sample sizes than girls, and although these studies are not representative of the entire Indian population or even a single province, they show little knowledge of STIs both among boys and girls (24;27). Studies have also shown that Indian school-going boys are more likely to debut sexually either with a sex worker or with an older member of the family under unsafe conditions (24;27). Studies on married adolescents and sexual experience indicate the lack of sexual autonomy being the recurring theme in decision-making processes (5;24;27;32;41).

Although the studies presented above paint a very good picture of the sexual and reproductive health of adolescent Indians, there are certain limitations to these studies that are noteworthy. For instance, data from the Population Reference Bureau (17) illustrate that adolescent girls in India are less likely to both attend school and complete secondary school in comparison with their male counterparts. Only thirty nine percent girls are enrolled in secondary schools in comparison with fifty nine per cent boys. Albeit a rise if compared to mid 1950s, these numbers indicate that the victims of child marriage do not necessarily go to school. Thus, studies looking at sexual and reproductive health of adolescent girls within the context of child marriage may target the wrong population in portraying girls' health needs.

Furthermore, the PRB also estimates that about forty percent girls and twenty per cent boys aged between fifteen and nineteen years are illiterate. This also means that studies using English magazine surveys are not targeting the correct populations, and the true scope of the problem of sexual and reproductive health needs of this population may not come forth. The National Family Health Survey- II shows that adolescent pregnant girls are more likely to give birth at home rather than at a hospital than women in their early twenties (14). Thus, the hospital samples concerning the quality of care provided to different age groups may not be representative of the population really engaging in child marriage. Finally, using more boys than girls in screening for sexual and reproductive health needs, practices and attitudes towards marriage also paints a skewed picture in establishing the needs of young girls.

Concluding this section, one may suggest that several knowledge gaps exist in establishing the true sexual and reproductive health needs of young girls living in rural settings engaging in child marriage. Knowledge gaps also exist in establishing why the practice of child marriage is still prevalent despite the fact that adverse health outcomes related to early sexual initiation and pregnancy are known, why young women's health is controlled by the husband's family, husband's knowledge of sexual and reproductive health, parents' knowledge of their children's sexual and reproductive health needs; interaction between parents and children on sexual health issues and knowledge regarding contraception use and sexually transmitted infections in young individuals residing in rural India.

2.4 Conceptual framework for this thesis

2.4.1 Shaping of Sexual and Reproductive Health Rights

Although this thesis does not follow a particular theoretical model, it uses the Human Rights perspective in understanding the health and social outcomes of early marriage in young married women, and how these outcomes are either breaches of their human rights or protect their birth rights.

Reproduction is essential for the growth and sustainable development of any country. However, increasing population is also of concern due to the never-ending battle of resources. Naturally, sex and reproduction are also of importance culturally, and every culture operates on the notions of sexually accepted behaviours and taboos. Every culture also recognises the need to reproduce, and this is reflected in national, cultural and religious documents. Sexual behaviours are often related to an individual's level of chastity, where culturally accepted sexual behaviours are hailed as being morally correct and unaccepted behaviours often result in punishments. It is important to note, however, that what is morally correct or incorrect sexually varies considerably across cultures despite the existence of global documents on how sex and reproduction should be viewed. National laws are products of what is socially, religiously and culturally acceptable in a certain country. Legal age of when one is allowed to have sex or marry vary across the globe as well. Cultural acceptability of appropriate sexual behaviour may, in turn, vary considerably from the legal definitions (44).

The framing of the *Universal Declaration of Human Rights* in 1948 (33) brought these discussions to international conferences, and have been instrumental in the development of sexual and reproductive health rights, which are now an integral part of the Human Rights convention. The framing of these rights, however, have taken several decades as the initial international conferences focused mainly on exchanging scientific information on population variables (e.g. World Population Conference, Rome, 1954) and on analysing fertility as part of the policy for development planning (World Population Conference, Belgrade, 1964). These conferences were only attended by global experts on population studies and excluded political agents from all respective UN countries (39). This meant that population issues were not put on an international political agenda before the third world population

conference, which took place in 1974 in Bucharest, Romania. 1974 was called the “World Population Year”, something that translated into international political commitment towards demographic aspects of population (45). Population issues-fertility and increasing population-were seen as an integral part of socio-economic development policies but no solution was reached as to how one would deal with the increasing population crisis globally. However, it was at the 4th world conference on Women in Beijing that sexual and reproductive health issues were put on the global agenda by providing a universal framework for what has come to be known as sexual and reproductive health and rights (46). Although the Beijing conference put these issues on global agenda, the nature of these rights is contentious. Some critics of these rights suggest that these rights, albeit important, fail to recognise reproduction being a factor of sexuality, and concentrate on sexuality being a factor of reproduction instead (39). An example of this is the Millennium Development Goal 5, whose primary focus is reducing maternal mortality (a function of reproduction) and achieving universal access to reproductive (and not sexual) health with respect to antenatal care and population control. Thus, there is still room for improvement in these laws.

2.4.2 Putting Human Rights into practice and their relationship with early marriage

Sexual and reproductive health and rights are an integral part of basic human rights, which can be used as tools to understand concepts such as early marriage. The fundamental right to health was first codified in the Universal Declaration of Human Rights at the UN General Assembly in 1948 (33). Despite their long history, sexual and reproductive health rights are not understood as being relevant by many healthcare groups (47). Sagade suggests that by ratifying the international conventions (The Declaration of Human Rights, for instance), state parties accept a legal duty to abide by these conventions, and thereby, are obliged to take steps to protect the exercise and enjoyment of human rights, to investigate violations, and to provide effective remedies to the victims (32). A human rights framework, therefore, provides an empowering framework for protecting vulnerable and at-risk populations. Young girls who are married (off) early are one such population that is at risk due to early marriage. In the context of early marriage, a state can be held responsible for the ‘lack of diligence in preventing through its executive, legislative, or judicial organs the individuals who private act of contracting early marriage’ (32) However, in reality these rights are not directly

translated into daily practice, such as privacy, informed consent, confidentiality, and non-imposition of an individual's religious beliefs on others (47). Thus, there is a need to strengthen the practice of these universal 'laws' that can be used to protect and safeguard the lives of millions of individuals.

For the purpose of this thesis, I will be using different articles within the human rights framework to test for whether the practice of early marriage violates the basic rights of the girl or not.

I. Right to Life:

The Article 3, of the Universal Declaration of Human Rights (33) states that everyone has the right to life, liberty and security of person. The practice of early marriage, therefore, can be seen as a violation of this right as young married women are at a higher risk of morbidity and mortality due to the early onset of sexuality and sexual problems (41).

II. Right to Health:

The Article 12 of the International Covenant on Economic, Social and Cultural Rights outlines that every human being has the right to the enjoyment of the highest attainable standard of physical and mental health. Early marriage violates a girl's right to health. This is particularly true in the case of sexual and reproductive health rights, which are part of the right to health. This is because the right to health requires four interrelated features: availability of services; accessibility of services and information; acceptability of services and evidence-based technology and services of good quality (47). Although healthcare may be available and of good quality, young brides may not be able to access healthcare due to lack of self-autonomy (11) and/or healthcare may not be suited to the needs of young people (21).

III. Right to Education:

Young brides are often taken out of school or denied complete access to education. Some parents choose not to send their girls to school because of the anticipated higher level of dowry they have to pay if the girl gets educated (2;27). The Article 26 of the Declaration of Human Rights states that "everyone has the right to education, which should be free, at least, in the elementary and fundamental stages". Holding girls away from education, therefore, can be seen as a direct violation of their rights.

IV: Right to Consenting Marriage:

According to the Article 16 of the Human Rights framework, marriage shall be ‘entered into only with the free and full consent of the intending spouses’. A number of studies show that most early marriages are not entered with free and full consent of intending spouses but as a result of submission to parents’ requests (2;6;27;31;34;41).

Not only this, early marriage also violates certain other rights that are vital to the full physical, physiological and psychological development of the girl child. These are the right to privacy, the right to be protected from harmful practices, the right to freedom from abuse and exploitation and the right to participation (29). Early marriage can be seen as a harmful practice that hinders the full growth of a child, and thereby, a violation of one’s right to be protected from harmful practices. The right to privacy is of relevance especially in meeting with the healthcare system that may or may not be youth friendly. As young married women are more likely to accept physical abuse and violence within their marriages than older women, it is also a violation of their right to freedom from abuse and exploitation (38). The right to participation is at threat as young married women may not possess control over their own bodies with respect to mobility and decision-making related to sexuality (11).

The findings of this study will primarily discuss in how far socio-cultural practices related to early marriage in Shivgarh, Uttar Pradesh, are violations of the rights of young married women.

2.5 Rationale for this study

As mentioned above, Uttar Pradesh is the most populous province in India, where the practice of early marriage is both socially and culturally accepted. Uttar Pradesh is also one of the eighteen states where the Ministry of Health and Family Welfare established the National Rural Health Mission in 2005 (19). Thus, the network of Accredited Social Health Activists and Auxiliary Nurse-Midwives operate within the villages of Uttar Pradesh. These community health workers work under a number of government initiatives, such as the reproductive and child health programme, RCH-II. However, little is known as to what types of health advice these health workers give to rural women and how they meet the needs of young married women. Further, little is known as to what types of healthcare advice is given to young girls and married women planning for family, and how these health workers

mobilise and involve local men and women with respect to improving their health. Furthermore, little is known as to general sexual and reproductive health education is provided within their programme, and whether both men and women are included in the programmes.

The proposed study aims to understand why the practice of early marriage still exists in Shivgarh when it is illegalised through national laws; how young married women perceive their married and sexual lives; what the context of sexual health decision-making is; and what types of sexual and reproductive health services are available to them and how they access these services. The concepts access and availability are understood through the lens of human rights framework, where healthcare should be widely accessible and available to the citizens of a nation. It is important to conduct this study because it can aid our understanding of early marriage within this context and help create interventions that are appropriate for the victims of early marriage – the young married women.

3. Research Question

The main research question that this study attempted to answer was: what is the nature of sexual and reproductive health services available to, and accessed by young married women in Shivgarh, and how do these health services uphold the human rights of these individuals.

3.1 Goals and Objectives

3.1.1 Goals

The broader aim of this study was to gain a deeper understanding of the context of early marriage and sexual and reproductive health issues in Shivgarh.

3.1.2 Specific Objectives

More specifically, the objectives were to:

1. Explore the reasons for the existence of early marriage in Shivgarh;
2. Describe young married women's perspectives on their married lives;
3. Explore the context within which sexual and reproductive health decisions are made; and
4. Explore the nature of sexual and reproductive health services available to, and accessed by young married women in Shivgarh

4. Methodology

4.1 Study Design

When deciding for which methods were best suited for the purpose of this study, it was important to examine a number of ontological and epistemological questions that define the way research is conducted. Whereas, epistemology relates to the nature of knowledge and how this knowledge can be obtained (48), ontology refers to the notion of whether there exists one single objective reality (48). The main purpose of this study was to understand the nature of sexual and reproductive health services available to, and accessed by young married women in Shivgarh. As this enquiry was considered to be exploratory and descriptive in nature, it was decided that a qualitative design was best suited for the purpose of this study.

Furthermore, the constructivist theory of epistemology (48) was used in conceptualising the so-called 'objective' reality in this study. Constructivist theory states that 'reality' is socially constructed and is shaped by social factors such as age, gender, race, class and culture (49). In other words, this theory takes a culturally relative approach in understanding social structures. One of the interviewed groups in my study constituted a vulnerable group due to their age, gender, class, socio-economic status and involvement in an illegal practice (marriage in adolescence) according to Indian Law. I found it appropriate to view these issues in the light of constructivist theory rather than labelling my participants' truth as less valid than mine. Thus, this study did not aim to shed light on how these individuals should be brought to justice in the court of law and their practices, irrespective of being illegal, were respected as being their culturally constructed truth. The question of how these qualitative data were obtained is dealt with in the section on data collection strategies.

4.2 Timeframe

This timeframe of this study was set according to the University of Oslo standards for carrying fieldwork research for the fulfilment of a master's degree in International Community Health. The first term of the second year was devoted to designing and planning for the study and in preparing a protocol, an Ethical Clearance document and in gaining resources from various agencies to carry the fieldwork. The second term of the second year

was devoted to complete fieldwork. Due to a delay in ethical clearance from India, the fieldwork was carried out between October and December 2008. However, I spent time interacting with the villagers and getting to know them from August until October 2008.

4.3 Study Site

The study was conducted in Shivgarh, a rural block in Uttar Pradesh, India. Shivgarh has a population of approximately 105 000 (40), and is divided into 39 village administrative units. These administrative units comprise 5-7 hamlets of small rural compounds with approximately 100 households each.

Shivgarh was chosen as a research site for many reasons. The rural block is situated in the most populous province in India. It is estimated that about sixty one per cent of all girls residing in rural Uttar Pradesh marry before the age of eighteen years in comparison with the national average of fifty two per cent for rural India (14). Using these data, one could deduce that marriage in adolescence is a rural phenomenon. Shivgarh, therefore, served as a prime example of a target population for this study.

National estimates illustrate that Uttar Pradesh is one of the five states in India with some of the lowest health (e.g. life expectancy; infant mortality rate; maternal mortality rate) and social development (e.g. clean, piped water; literacy rate; access to electricity) indicators (14). The fact that rural areas present poorer health and social development indicators than their urban counterparts; this only strengthened the need to explore whether these factors were in any way related to early marriage. Shivgarh, thus, provided a platform for exploring this particular aspect.

Moreover, the Johns Hopkins University led King George's Medical University (JHU-KGMU) Collaborative Centre in Lucknow, Uttar Pradesh, carried out an extensive study testing the effect of a community-based behaviour change management on neonatal mortality in Shivgarh block (40). To date, it is very difficult to document birth, marriage and death in India due to the lack of consistent registration methods (50). As the Shivgarh study had already mapped the entire population in Shivgarh for age of marriage, number of households and individuals per hamlet, level of education, number of births per year, and carried age autopsy for those without birth registration forms; this made it easier for me to operate on concepts such as age autopsy alongside this information.

Uttar Pradesh is also one of the five provinces where the Norway- Indian Partnership Initiative (NIPI) works. Thus, these organisations became my entry point into the Indian rural health system due to the active involvement of my co-supervisors in both projects.

4.4 Study Population

Using the WHO definition of adolescents (21), this study initially wanted to target young people between the ages of ten and nineteen. However, this was not possible as the Regional Ethics Committee in South-East Norway objected to me interviewing adolescents between the ages of ten and fourteen. This group was considered to have a higher level of vulnerability and it was thought that the interviewing process may harm them psychologically if the interviews were not carried out properly. Thus, the target population had to be adjusted according to the Ethics Committee's guidelines, and only girls between the ages of fifteen and nineteen were included in the study.

Due to the short timeframe of this study, JHU-KGMU group based in Shivgarh became a vital entry point in contacting community members as well as community health workers working in Shivgarh. Only community health personnel working on a grassroots level in Shivgarh, and girls between the ages of fifteen and nineteen from Shivgarh were interviewed for the purpose of this study.

Young married women were chosen for two reasons. First and foremost, the purpose of this study was to explore the phenomenon of early marriage. Secondly, global studies on sexual and reproductive health show that data on pre-marital sex from India is scarce, and that although young Indian men and women have pre-marital sex, sex is primarily seen as the domain of marriage in this culture (24;27). Due to the short time-frame of this study, it was decided to simplify the study by using married participants, and thereby, assuming that they were sexually active due to their marital status.

4.5 Inclusion and Exclusion Criteria

Young married women were included if they:

- were between the age of 15- 19,
- were female,
- were married and lived with their husband,
- resided in Shivgarh block,
- were willing to be interviewed,
- allowed me to tape the interviews and make notes, and
- if they were willing to be followed up to clarify answers or to answer additional questions.

Young women were excluded from participation if they:

- were unmarried,
- had got married but had not yet moved to their bridal home,
- did not wish to participate for any reasons, and
- if they hesitated in talking about their sexual health with us.

Health workers were included if they:

- worked as community health workers in Shivgarh block,
- were either an Accredited Social Health Activist (ASHA) or an Anganwadi Worker (AWW),
- had been working in Shivgarh block as a community health worker for at least a year,
- were willing to let me observe them in the field and make notes,
- were willing to be interviewed and allowed me to tape the interviews,
- agreed to take part in a group interview after the interview, and
- if they were willing to be followed up to clarify answers or answer additional questions.

Health workers, who did not meet the inclusion criteria, were not asked to participate in the study.

4.6 Sampling Technique and Sample Size

Purposive sampling was adopted for the purpose of this study, a commonly used technique in qualitative research methods. According to Patton, subjects are not randomly selected using this technique but selected with a purpose, often because they may provide rich information related to the research topic (51). He further suggests that within purposive sampling, one may use various techniques to either vary a sample from the one extreme to the other (maximum variation) or consider a sample that is focused, and reduces variation (homogenous sample) or have a criterion based recruitment.

For the purpose of this study, various purposive sampling techniques were used. For instance, all of the community health workers and adolescent girls were recruited based on set criteria. The adolescent sample was homogenous in the sense that the participants all lived in a rural area, had access to the same primary and community health centres, had the same socioeconomic status, and were between the ages of 15 and 19. The health worker sample, albeit homogenous in the sense that they either worked as an ASHA or an AWW and lived in Shivgarh block; they varied in socioeconomic status, marital status, number of children, age, religion, and length of tenure. Adolescent girls were also asked if they knew other girls who was the same age as them and married. Thus, snowballing became an important tool in sampling.

It was initially planned that I would carry out one set of in-depth interviews with health workers and young girls, two focus group discussions with health workers (one before interviewing young girls and one after), and carry non-participant observations both before and during the interviewing phases. However, I soon realised that due to the sensitive nature of the study topic, it was not possible for me to carry out focus group discussions with the health workers. As I had to ask questions rather than just give them ideas on what to discuss, the focus group discussions had to be re-adjusted to group interviews. The individual as well as group interviews followed a pattern of data saturation (51). The process of data saturation meant that data collection was considered to be completed when no new insights and/or concepts emerged from the interactions, and if the participants had been exhausted.

Initially, I also wanted to include the auxiliary nurse-midwives (ANM) in my study but decided against it as I was told by the ASHA that the ANM did not directly contact the local

villagers but that all villagers had to go through the ASHA or the AWW to get to the ANM. As my initial visits to Shivgarh showed that the ANM worked as a skilled birth attendant and gave vaccines to children and pregnant women, and her contact with villagers was through the ASHA, I decided to only interview the ASHA from the National Rural Health Mission and the AWW from the Integrated Child Development Services. Their roles have been described earlier.

Additionally, I had anticipated that I would interview 15-20 young married girls, and health workers each. Using Kumar et al.'s (40) study in Shivgarh, it was decided that I would only target the control area of their intervention in order to avoid studying the same population several times. However, this was soon abandoned as the formative research from Shivgarh showed that the intervention focus and the types of questions asked were different from the ones this study was interested in asking. The main focus of Shivgarh intervention had been on neonates and not on sexual health. It was, therefore, decided that I would include the intervention arms in my study.

It had also been anticipated that it would be possible to conduct as many as 20 in-depth interviews each with both health workers and young girls. However, what was not anticipated that as this study concerned very intimate issues as sexuality and sexual practices on an everyday level, that I would have to invest more time in simply gaining the confidence of the community members. Thus, it was only possible to conduct 8 in-depth, individual interviews each with health workers and young girls. Another issue that delayed the data collection process was gaining an Ethical Clearance from the regional committee in India, which was delayed due to the re-election of a regional ethics committee in Lucknow, Uttar Pradesh.

4.7 The recruitment process

The JHU-KGMU Collaborative Centre and the Shivgarh team members were essential in gaining access to the research field. Shivgarh team members made it possible to identify the households of married adolescents, location of local Anganwadi centres and the ASHA's place of abode. They were also helpful in arranging transport and providing me with fieldwork assistants who knew most of the villagers. The fieldwork assistant made the

process of getting to know the villagers easier for me. Through their work in Shivgarh, Kumar et al. had disclosed to me that it was initially very difficult for researchers to gain trust in the community but as they had worked in Shivgarh for nearly ten years; they were now respected members of the community. Thus, if I was accompanied by a Shivgarh team member in the initial stages of my data collection, it would be helpful for me in the earlier stages of the data collection. This was, indeed, the case and facilitated the interview process preliminarily.

The timeframe of the research project coincided with the Indian festival and marriage season, which could mean that I would either not meet the targeted population due to their involvement in religious recitals or travel out of town to various weddings. In order to get acquainted with the community members and make them aware of my project, I decided to visit Shivgarh for the first time during a village religious recital. During this event, most men and women engage in reciting the Hindu scriptures and sing hymns for prosperity and wealth. The village administrative members are also present at such meetings, and are seen as the gatekeepers of society. Thus, it was important to include them when informing the villagers about my study. At the assembly, the Shivgarh team members introduced me as a Norwegian-Indian researcher who would visit their village several times the following weeks and discuss women's health issues with young married women.

I decided to interview the health workers before interviewing adolescent girls as I wanted to gain an overall idea of how these community health workers worked in the community and what kinds of issues they dealt with on an everyday basis. Further, I also wanted to gain an idea of their notions of sexual and reproductive health problems and solutions. The health workers were recruited through the Shivgarh team as their formative research had identified all community health workers working in the area. As the ASHA do not have a fixed work schedule and their work place is the community itself, my research assistants and I considered it appropriate to talk to them when they were working in the field or when they were at home. The latter was not seen as intruding with their privacy as my research assistants were respected highly in the community, and I was told that the villagers considered it as an honour if we visited them at their house. After explaining the purpose and scope of my study and briefly telling them about myself, I asked the health workers when and where they wanted to be interviewed and if I could follow them in their work. Depending on

their daily schedule, the interviews either took place on the same day consent was obtained or at a time more convenient for them.

During the first assembly session, I was introduced to an adolescent bride who was pregnant. My research assistants asked her if she would be interested in hearing about my study. She responded positively and we arranged a time to sit and talk. At the end of the interview, I asked her if she knew any other girls her age who were married. Through her, I was introduced to three of her closest friends who were married. Out of these three, one decided to partake in my study. At the end of each interview, my research assistants or I would ask the participant if she knew of any other girls who were married and her age. Most of the participants would talk about their friends or sisters and tell us whether these individuals were at home, out of town or married into a village outside Shivgarh. Thus, snowballing was used actively as a technique to find potential participants. We asked the same question of acquaintance to gain knowledge regarding any potential participants in the case where interactions did not translate into interviews.

None of the participants were paid for participating in the study. The participants did not incur any travel costs as I met them at the places where they wanted to be interviewed. Health workers either wanted to be interviewed at their health centre (AWW) or at home (ASHA). Adolescent brides were interviewed at their place of abode. As a measure of gratitude, I offered to put them in contact with any health personnel if they required any assistance. The group interview with health workers was conducted at the JHU-KGMU Shivgarh office, where I provided lunch and transportation to all participants.

4.8 Refusals and Missed Opportunities

Those who declined were comparable to those who participated in both groups. Although we never required why individuals did not participate, all women provided reasons for not participating. One of the AWW scheduled a later time for the interview but sent her son to inform us that she could not participate because her sister had just delivered a baby and she would be busy. Two others told me that they did not feel comfortable in discussing sexual and reproductive health issues with me and did not see it appropriate to participate in my study. One health worker talked about her role in the community but did not want me to use

her interview in my analysis. Another health worker told me that she was tied up with housework and the holiday season. In short, either housework or openness in discussing sexual health issues was given as the main reason for not participating.

As for the other group, one of the participants wanted to talk to me but her mother-in-law found it inappropriate for her to do so, and refused us an entry to their house. Four girls were out of town when we visited them and when asked when they would return, we found that it was outside the timeframe of the present study. One girl did not want to be taped and did not want us to use her interview in the analysis as she found it difficult to talk about her experiences. One of the girls we met had just been thrown out of her husband's house and was now living with her mother and did not see it appropriate to talk to us.

In most cases, however, a potential participant was not missed because they refused to participate. They were missed because we would be in the process of interviewing someone. Although we resolved this for a couple of the cases, most opportunities were missed as the women were either going out of town to attend weddings and would not be back for a month after the timeframe of the study or did not want to talk to us at another point.

Another reason for missed opportunities was if the family members sat around us despite our efforts to only talk to young married women. As the girls found it difficult to openly discuss their sexual health with us in front of their family members, they refused instead of arranging a different time.

4.9 Data Collection Strategies

Interviews (open-ended, in-depth and semi-structured), one group interview and non-participant observations were the main data collection strategies in this study. Supplementary to these were the formative research aggregate data on demographics from Shivgarh and focus group discussions with Shivgarh team members prior to, during and after the interviewing process. The focus group discussions were used as a tool for designing interview guides, and in discussing findings after each interview. The focus group discussions were also used to make the interview guide as culturally relevant as possible.

All interviews were conducted with the help of a set interview guide and a tape recorder. During the data collection process, my research assistants served the purpose of establishing initial contact with the participant and in translating any unclear or difficult terms from Hindi to English.

4.9.1 Non-participant Observations

Non-participant observations were carried out throughout the entire duration of my stay in Shivgarh, and can be divided into three stages: before, during and after interviewing participants. I conducted 20 observations that were four-five hours long spanned over 20 days. The observation sites were the houses of married, most often, pregnant or new mothers and the AWW centre. At the end of the observation period, I also visited the local primary care centre to see where most deliveries occurred and what types of health services were available to the women on the primary healthcare level.

Observations were used for various reasons. First and foremost, observations were used a tool to illustrate a certain visibility in the field. This was done to gain the trust of the villagers and to get familiarised with their everyday life. As this study concerned topics of sensitive nature, I realised that I had to gain the trust of the villagers in order to engage in conversations with them. Thus, I used the opportunity to follow health workers in the field as an entry point in the lives of the villagers.

Secondly, non-participant observations became a vital tool in understanding the content of the interactions between health workers and community members. As the interviews were personal accounts of either information given or obtained, the observations became essential in outlining the types of interactions that really occurred in the field. I could watch and record various characteristics and behaviours without participating in the activity. Thus, the observations worked as a verification method in assessing whether health workers were actually giving the information they thought they were giving and how the entire conversation took place.

Observation notes were conducted using an observation checklist (Appendix V). The things that we paid attention to were:

- How health workers establish contact with married women,

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- Interaction between health worker and married women,
 - Using and explaining technical terms,
 - Place, seating arrangement, eye contact,
 - Time given to each woman,
 - The types of issues discussed during the visit,
 - Effect and presence of anyone else on the conversation, and
 - Facilities for family planning and delivery for pregnant women and mothers at the primary healthcare centre.

Alongside using the checklist, I documented not only the contents of the interactions but also how things were said. I documented the body language, tone and moods in which information was given and received. For instance, I documented the words that were whispered, shouted out loud, laughed at or ignored. Special attention was given to how words related to sexual and reproduction (e.g. intercourse, menstruation, discharge) were discussed.

4.9.2 Semi-structured Interviews with Health Workers

An interview guide was prepared before conducting semi-structured interviews with community health workers. Although giving the participant and researcher some room for probing and discussing issues that are not part of the interview guide, a guide would act as a checklist in ensuring that the same type of information was collected from each participant. Two focus group discussions with the Shivgarh team led to establishing an appropriate set of questions (Appendix VI). This process was also facilitated by reading set guidelines on the roles of ASHA and AWW.

The purpose of interviewing the health workers was to explore health workers' understanding of young women's sexuality and reproduction in general, and to assess the relevance of health services provided to married adolescent girls in particular. These interviews would pave a way for me to understand what issues were relevant for health workers, whether they advocated certain methods of family planning and whether their perceptions coloured their advocacy.

During the piloting phase of building an appropriate interview guide, it was established that it would be important to discuss less sensitive issues at the beginning of the interview. Thus, it was decided that I would enquire health workers about the content of their training, their work schedule, types of information considered most relevant, types of information provided, and motivation to become a health worker prior to enquiring them about questions related to young women's sexuality.

Between October 1, 2008 and October 15, 2008, eight interviews were conducted. The duration of each interview ranged between forty-five and ninety minutes. Two AWW and six ASHA participated in our study. We interviewed the AWW at their centres and the ASHA at their homes.

4.9.3 In-depth Interviews with Young Married Women

Young married women were interviewed after the health worker interviews as following the health workers in the field would increase my knowledge of village customs and facilitate the interviewing process. An open-ended, in-depth interviewing technique was used to interview young married women. An interview guide with certain core themes was used for the purpose of this interview (Appendix VII) and participants were probed extensively throughout the interviewing process. An open-ended approach to interviewing allowed the participants to share their stories with us in their own words and in discussing any topics that were of relevance to them. The main themes included the meaning of being an adolescent and being married, the participant's role in her family, perceptions regarding sex, importance of menstruation, importance of having a baby, making decisions related to sexual health, and perceived relevance of health services available to these girls. All interviews were carried out at the participant's home.

Due to a village custom, we were not allowed inside the house of the participants but had to sit outside in the "open, common" area. We often found this problematic as the older village women would interrupt the interviewing process by coming and sitting next to us. In order to protect the confidentiality of the participants, we had to stop the interviewing process and re-start at a later stage. The research assistants served the purpose of explaining to the villagers what we were studying and that we could not involve them in the interviewing process at that particular time. However, in order to show respect to the elderly, we would talk to them after

the interview. This would, in turn, allow us to gain a cultural insight in how the villagers arrange their lives.

I conducted eight in-depth interviews with young married women between November 10, 2008 and November 30, 2008. In one of the cases, we had to interview the husband of an adolescent bride in order to interview her. This interview has not been included in the analysis and only worked as a background to this study. The interviews ranged between sixty to hundred minutes.

4.9.4 Group Interview with Health Workers

A group interview was conducted instead of a focus group discussion at the end of the interviewing phase with health workers. A focus group discussion regarding sexual and reproductive health could not be conducted as the participants had to be probed extensively throughout the interviewing process. It was, therefore, decided that it would be just as fruitful to carry on with the interaction as a group interview. A list of themes discussed in the group interview can be found in the Appendix VIII.

Here, we built on the topics discussed in individual interviews with the health workers. All eight health workers participated and the group interview lasted for 2 hours and thirty minutes. As there had been a week's break between the individual interviews and the group interview, I started the discussion by introducing some of the topics that the participants had discussed during the individual interviews. I also gave them a summary of their main discussions with me. My research assistants took notes of the main themes discussed during the group interviews and acted as facilitators in turn-taking.

Not all of the issues discussed in the group interview were of direct relevance to sexual and reproductive health but are included in the final analysis as they would shed light on some of the aspects that would discourage a health worker from functioning appropriately in the field, and thereby, not giving out important information or listening to their clients. These issues related to wages, being depository of certain medications (analgesics), relationship with the area Auxiliary Nurse Midwife (ANM), collaborating with the AWW in the field, and birth and marriage registration of community members.

The main topics of discussion included being depository of contraceptives (pills and condoms), health workers' perceived beliefs on various contraceptives and methods for planning for family, types of health advice given to young unmarried and married men and women engaging in sexual practices, perceived notions of when to get pregnant and shame, perceptions regarding early marriage and the importance of having babies and abortion in married and unmarried women. We also touched upon the topic of HIV-testing and the access to sexual health services on a primary healthcare level. Finally, we discussed their perceptions regarding the best method to protect oneself against pregnancy and sexually transmitted diseases (STDs).

The group interview were important in the sense that they were both used to verify the content of the individual interviews but also in gaining deeper insight into sexual and reproductive health issues. As I had become acquainted with the health workers during the observations and individual interviews, it was also easier for them to talk to me about sensitive issues.

4.10 Triangulation

The present study used two sources to obtain data- community health workers and young married women. As the dictated roles of ASHA and AWW overlap in the field of sexual and reproductive health, this study used both types of health workers in the data collection. This was also done in order to achieve an understanding of how these roles were translated into health workers' everyday schedules.

Triangulation is the process of cross-examination which can be defined as the combination of two or more data sources, methods or theories to test for one particular phenomenon (49;51). This process was used to circumvent researcher biases and overcome the inherent deficiencies of a single data collection strategy, thereby increasing the validity of the findings. Albeit also used in quantitative methods, this approach is most commonly used in qualitative research designs. Within-methods triangulation was achieved by combining two or more approaches to data collection in the same study. This was achieved in the present study by using a combination of individual interviews with both groups, a group interview with the health workers, and non-participant observations. Triangulation is also used to

increase the credibility of the data gathered. Gouba and Lincoln (48) define credibility as one of the four criteria for judging the soundness of qualitative research. Credibility is a concept that tests whether the results are believable from the perspective of the participant in qualitative research. Internal validity is the comparable term used in quantitative research. By using two or more methods of data collection, one is more likely to achieve credibility as one can test the same notion from various angles. Data obtained from non-participant interviews, individual interviews and group interviews were analysed separately, and then compared as a way to ensure credibility of this study.

As mentioned above, focus group discussions with the Shivgarh team members were used to make the study more culturally relevant. This not only enhanced the rigour of this study but also ensured ecological validity of the present study, thereby achieving triangulation on various levels.

4.11 Enhancing the Quality of the Study

In order to enhance the quality of the study, the collected data was frequently reviewed through discussions with my supervisors. Any new emerging themes, concerns and interview guides were discussed both with the Shivgarh team members who had been responsible in the data collection process of the Shivgarh Block study as well as with my supervisors. Whereas the ground team provided with culturally relevant and appropriate ways to approach individuals, to gain trust in the community, and to explore sensitive topics; my supervisors and I discussed the conceptual framework of data collection strategies and the possible implications related to exploring a socially sensitive topic. All interaction was documented and shared with all parts involved in the designing of my study.

One of the main findings of this study was that participants did not know their age. As this was one of the main inclusion criteria to participate in the study, age-autopsy was used as a tool for age-approximation alongside Shivgarh demographic data, as collected by Kumar et al. in their research on neonatal mortality in the area (40). Several techniques were used to deduct an individual's near-enough real age. These techniques were asking participants about specific historical events relevant to Indian history the past 25 years, and asking mother-in-laws where participants considered this relevant. I refer to these techniques as the "age autopsy". Age autopsy involved asking questions such as "Do you remember when Rajiv

Gandhi⁷ was murdered?” or “Do you remember when Indira Gandhi⁸ was murdered?” Remembering both events would act as an excluding criterion and if none of the events were remembered, then we would proceed with other questions of the same kind. Another question was if participants remembered when they had their first menstruation. The responses ranged between one and three years in each case. This alongside confirmation from mother-in-laws became the final tool of age deduction.

The fact that I spoke Hindi and learned the local dialect of Avadhi made it easier for me as a researcher in understanding the participants. In this manner, I did not need an interpreter when interviewing the women or in understanding the context and content of interactions. My research assistants, however, acted as my supporters and translated terms that I did not understand from Hindi to English.

4.12 Research Assistants

Two research assistants were appointed for the purpose of this study. One of the research assistants was part of the Shivgarh ground team and had worked within their formative research groups for the past five years. The second research assistant was appointed from a pool of fifteen applicants. She was later hired by the JHU-KGMU research team for further research. The first research assistant was hired because of her knowledge of the study site, language and villagers. She did not speak English but was able to explain certain local words to me in Hindi, which made the interviewing process easier for me. The second research assistant was hired because of her knowledge about culturally sensitive issues. She had previously worked with HIV and AIDS and men’s sexual health in urban Uttar Pradesh and could translate certain Hindi words that were unfamiliar to me. She also provided key insights into the interpretation of certain statements and acted as my supporter in designing of a culturally appropriate interview guide. Both research assistants were paid 4000 INR each (541NOK) per month for their support.

⁷ Rajiv Gandhi was the seventh Prime Minister of India and was murdered in 1991.

⁸ Indira Gandhi was the first female Prime Minister of India, and was assassinated by her bodyguards in 1984.

The informed sheet were translated to Hindi by the JHU-KGMU staff and translated back to English by me. They were also read by my research assistants and modified before sending to the Regional Ethics Committee for approval.

4.13 My role as a Researcher

A plethora of research body illustrates the importance of researcher's role in the outcome of the study (49). Where the researcher's background, knowledge, attitudes and skills play a critical role in establishing trust and gaining rich information; a researcher can also risk not gaining intimate information precisely because of the way she presents herself to the hosts (49). Thus, it was important for me to consider how I would establish trust and gain access to sensitive and rich information, and how my persona could either aid or mislead my study.

Prior to thinking how '*who and what I am*' would '*help*' me in my research, it was essential to reflect on the reasons why I was interested in exploring a sensitive topic. I have a background in psychology, with an emphasis on health and biological psychology. I have also worked with vulnerable individuals- adults and children- in a number of settings, and actively supported certain political and non-governmental organisations in their work with vulnerable individuals in the UK and Norway. A personal interest in international health policy and human rights became my inspiration in studying an illegal phenomenon (marriage in adolescence) and understanding how individuals living in such life situations view their sexual health. Through my work with vulnerable individuals in Europe, I have always been interested in how the health system can make the lives of vulnerable individuals easier and better. Thus, I was interested in how the community health workers dealt with such issues and in identifying how one could provide optimal sexual health services to this target group.

I chose India as a study site not only because marriage in adolescence is a widespread phenomenon in rural India but also due to my part Indian heritage. Prior to conducting research in rural Uttar Pradesh, I had been to India three times but never visited U.P. In many ways, it was like visiting a different country and a different culture as my Indian family lives in urban India with access to most benefits of modern life. My heritage became an asset in understanding the underlying norms of rural societies in India, something which could have easily been missed if I was a non-Indian. As their thinking was not foreign to me per se, I

saw this as my greatest strength in gaining information. Further, I was also aware of the codes of conduct in Indian society, which made it easier for me to put myself in a researcher's position. However, not having lived in India and only attained Indian heritage and culture through my family, was not enough in understanding and relating to my participants. Although speaking Hindi and learning the local dialect became an asset in gaining trust and understanding the concerns of my participants; not being a native speaker was a limiting factor in the initial stages of the interviewing process.

The most important strength in gaining sensitive information regarding sex was me being a woman. I could relate to their feelings, concerns regarding sexuality and understand their fear of not being able to give birth to a child. Although I cannot be certain but I think that had I been a male researcher, it would have been very difficult for me to gain knowledge regarding my participants' sexual habits, the sense of pleasure related to having sex and fears related to their partners having multiple sexual partners. This was best illustrated by one of my participants (n=3), who said "*Didi, it is easier for me to talk to you about this because you also are a woman...*"

4.14 Data Management

Each interview was taped using a tape-recorder and transcribed verbatim directly in English by me. I also took summary notes during each interview recording the moods and tone of the conversation. All taped and written material was stored in a safe, to which only I had the key. The interviews were transcribed on my personal computer but the information was stored using a USB memory key in order to avoid any third party gaining access to the data in case of theft.

4.15 Data Analysis

Data analysis was conducted simultaneously with data collection and data interpretation. Observations were analysed by making a descriptive narrative of each situation and were used as supplements to interview data. The purpose of data analysis was to identify recurring themes and patterns in the interactions. Interviews were analysed using the techniques of

Interpretive Phenomenological Analysis (IPA) (52). Data were coded using the WEFT QDA software package and allotted various overall themes and sub-themes or categories for each interview. Further, a memo was written as a note on each participant describing the situation using observational notes from the interviews. The IPA analysis followed these steps:

- Transcribing the interviews verbatim and producing narratives of observation notes,
- Reading the transcripts to gain an overall impression of what the participants said,
- Re-reading the transcripts to understand the context that was shared and identifying meaningful constructs and labelling them as codes,
- Condensing and summarising the content of each of the coded groups by making a running document for all participants for each code, and
- Integrating the insights from running documents into broader themes that reflect the situation, and
- Preparing a findings document highlighting words/phrases to generate sub-themes to guide interpretation.

4.16 Dissemination of Findings

Throughout the data collection phase of this project, fortnightly reports were sent to all supervisors and my research assistants. Furthermore, findings were discussed as we proceeded with data collection at monthly meetings with the local co-supervisors in India. All parties were informed about the progress of data collection and analyses. Prior to leaving Shivgarh, I also had a meeting with the local team in Shivgarh, where we had discussed what I had learned as a research through an informal presentation. I also made a more formal presentation at the local host organisation before leaving.

Based on the requirements from funding organisations, I will provide a copy of my master's thesis to my local supervisor in India, to Save the Children, Norway and to Norway India Partnership Initiative at the Royal Norwegian Embassy, in New Delhi, India. Furthermore, I will also write a short report for the Save the Children, Norway magazine as requested by the organisation. In addition, manuscripts and abstracts will be written with the purpose of publishing in peer-reviewed journals and presenting at conferences. Finally, this final report

will be submitted to the Institute of International Community Health, at the University of Oslo not only to fulfil the official requirements of this Master's degree but also to help future students with their research projects and ideas.

4.17 Ethical Considerations

4.17.1 Ethical Clearance

The World Medical Association's Declaration of Helsinki (53) makes it very clear that all medical research involving human participation is subject to ethical standards to promote respect of and protect the health and rights of human beings involved in the research. The DoH also makes it clear that any study conducted should, first and foremost, benefit the research participant rather than researcher and the society on the whole. The Council of International Organisations of Medical Sciences (54), however, points out that a study can also be conducted if it benefits the group that the participants belong to and not just the individual herself. Taking these two guidelines into consideration and upon the realisation of the importance of ethical considerations related to medical as well as social sciences research, the research protocol will be cleared with the Department of International Community Health, Institute of General Practice and Community Medicine, University of Oslo; the Regional Ethics Committee, South Eastern Norway; and through the JHU-KGMU Ethics Committee, Lucknow, India before the commencement of this study. Permission will be sought from the District and State level health officers in Shivgarh, U.P. through the Johns Hopkins Shivgarh/Saksham Project.

4.17.2 Recruitment of Subjects and Informed Consent

As the research design involved data collection on three levels- observation, group interviews and interviews, informed consent was sought both from health personnel and from subjects being interviewed and observed. As health workers and the local community were already part of the Johns Hopkins Intervention, I can clearly see how subjects were more inclined to participate in my study. However, as community involvement was used an active agent in the intervention, participants were also made aware of the nature of the intervention and how the main purpose of the intervention to improve maternal and neonatal

health in Shivgarh/Saksham through simple healthcare advice. No monetary reward was given to the participants and a clear understanding of the voluntary nature of participation in the project was outlined. Although, I visited the same areas visited by Johns Hopkins Project, my target group were not primarily pregnant women in all ages. My target population was a specific sub set, if that, of the sample set used in Shivgarh Block, and may or may not be pregnant. Thus, I targeted a slightly different population than the Shivgarh project. Obtaining fair consent was not a hindrance as I made it very clear that I was not part of the same project as the earlier intervention, and that my research objectives were slightly different. Thus, I obtained informed consent from the health workers being observed, the girls being observed as part of the health personnel observation and the girls and family members being interviewed. As some of my participants were illiterate, an oral consent was obtained in the presence of a witness. This was most likely the head of municipality, a key informant or my research assistant. Informed consent forms are presented in the appendices III and IV. The procedures were read out where a participant is illiterate. Consent forms were translated to Hindi in order to help the participant understand the nature of the study.

4.17.3 Confidentiality

Measures were taken to protect the confidentiality of my participants. As I was interested in issues related to the sexual and reproductive health of young married women living in early marriage, I realise that it is an extremely sensitive topic to discuss and share. No names were necessary for identification purposes. Thus, the participants were not asked about their names or their relatives' names. All the names presented in this thesis are fictive. Each participant was given an observation number, a group interview participant number and an interview number. The only form of identification needed was the age and gender of the participant. However, as most of the participants did not know their age, an age-approximation was used. Sensitive information such as the number of family members in each compound, number of children, level of education in each participant and knowledge regarding contraception and STIs was also collected for the purposes of comparing the participants with each other and in understanding their socio-economic statuses. The observation checklists and interview guides as well as iTalk Dictaphone, and my computer were at all times locked in a cabinet, and the key was only available to me. Interviews were conducted in a setting that was most natural for girls – either their homes or in a women's

activity centre. Families were also made aware of the project in case a girl specifically requested that her family was told where she was spending her time. This was done to ensure that I was not burdening the participant in any way or shape. Participants were also informed as to the confidentiality procedures at the beginning of observations and interviews.

4.17.4 Risks and Benefits

As this study was qualitative in nature and sought to explore the understanding of sexual and reproductive health of young married women, no physical harm or risk was associated with this study. However, I realise that I was taking up valuable time from participants' every day life by interviewing them or by asking to observe them. In cases, where sensitive information was sought and a participant had experienced something traumatic – as loss of a baby, husband, a family member or found it very difficult to discuss openly her health concerns, I obtained the role of a listener and stepped out of the role of an interviewer. As it is important to realise that we are all fellow human beings who share a certain set of emotions when dealing with trauma or stressful life situations, it was suitable to both empathise and sympathise with one's life situation. If the participant requested further health information, I tried my best to put the participant in touch with the appropriate health workers but, at the same time, made sure that the participant at all times realised that I was in no position to help beyond a certain point. I only started interviewing or observing if the participant so wished and fully respected the participant's decision in not doing so.

On a short- term level, no benefits to the participants were anticipated through in- depth interviews. Using the CIOMS guidelines on medical research (54), the benefits of this research are seen to be indirect, and to the group that the participants belong to rather than just herself. It is important to realise the needs of an adolescent girl who is subject to child marriage in order for the health professionals to provide appropriate care and services catered to her need. It is also important to understand why a certain practice prevails, what sort of health- related justifications are made when parents marry off their daughters before they are physically mature, and how future health education may deal with these issues specifically. Through observing health workers and their advice given to pregnant women as well as through having a group interview with them, one can raise awareness amongst health workers about the concerns of young girls, and may, strengthen their work with them.

Hopefully, this will lead to thinking in newer directions as well as provide an assessment of how their work is received and appreciated. In short, I believe that the risks incurred by this study were minimal, and that the benefits related with such research justified the purpose of this study.

The participants did not receive anything for participating in the study. Health workers were provided with transport and lunch when they participated in the group interview.

4.18 Limitations of the Study

India is the second most populous and seventh largest country in the world. A small- scale research carried out in the district of Shivgarh, Uttar Pradesh, is not representative of the entire Indian population. In addition, as discussed above, the practice of child marriage is not common in the entire population, either. The fact that this study is a qualitative study also makes it difficult to generalise the findings to the rest of the population. However, it provides a valuable insight in the nature of issues that may be important to adolescents, their families, and health workers in a small community. Such a study may be conducted elsewhere to test for generalisation on a greater level. The short time allotted for the data collection is also a limitation to this study.

My partial Indian background was both an asset and a limitation to the study as I have certain beliefs regarding certain practices that may colour my judgment and perception. On the other hand, the fact that I did not reside in a similar community as my participants, shared their language and culture completely, and as I am not married and in higher education, I may also be prejudiced to a certain extent when met with how women should act in certain settings. On my part, it was very important to be aware of these issues but it was also equally important to have an open mind in learning women's and health workers' experiences.

5. Findings and Discussion

5.1 Introduction

This section presents both a descriptive account of findings from the fieldwork, using the voices of young married women and community health workers as well as a discussion on the implications of these findings for the participants. The quotes presented here are the words used by the participants, and have not been altered. The themes generated from our interactions follow the pattern in which the interviews developed. This section does not read findings in light of any particular theory but tries to present them using the human rights framework wherever possible and applicable. The findings are based on all data sources (interviews, group interview and non-participant observations), and are assigned to respective source where appropriate. The quotes and stories presented in the following chapters illustrate the issues I have chosen to emphasise in my thesis. These issues are coloured and constructed by the articles and books I read, by my own perceptions of being a woman, being partially-Indian, being an academic and have arisen from my interest in public health policies and law. Thus, these findings and discussions reflect more about the way I have perceived and constructed the participants' reality and should be read as such as well.

In the prologue, I introduced the story of Radha. This story was not analysed in the prologue but statements from Radha and participants like her lead the discussions and themes presented in four objectives. In order to preserve the identity of my participants, all names provided in the text, whether they are of young married women or health workers, are fictive. In this section, I have hoped to do justice to the issues that came forth from my interactions with young women and health workers, and to the stories that these women shared with me. The combined findings and discussions section is, therefore, divided according to the four specific objectives in order to paint a picture of these women:

I. Explore the reasons for the existence of early marriage:

In this section, I have divided the possible reasons for the existence of early marriage in two – socio-economic factors that may lead to early marriage and cultural norms that favour this practice. I present to the reader a postulate that poverty seems to be the underlying factor that leads to early marriage, and is manifest in the young women's access to education, birth certificates and knowledge of age. Cultural norms that favour this practice seem to be conservative views on pre-marital sex and sexuality, and women's lack of self-autonomy.

II. Describe young women's perspectives on their married lives:

In this section, I present to the reader how young women think about the content of marriage, and the roles and responsibilities associated with being married. Young women express the notion of being obedient to their husbands as the main content of being married, and describe how taking care of the family and having sex are responsibilities related to being married. I discuss this finding up against the cultural norms of being an 'ideal wife' and how women crave to be this Satimata, the protective goddess.

III. Explore the context within which sexual and reproductive health decisions are made:

Here, I discuss what women relate to as being sexually active, why one should be sexually active and what influences are present in the physical surroundings of these young married women when they make sexual and reproductive health decisions. I describe a sense of obligation that is described by women in being sexually active, and how it serves the purpose of either economic stability or in upholding their self-worth or both. The participants and health workers discuss how mother-in-laws and husbands become the main agents of influence and how migration of husbands to the cities can also affect these decisions.

IV. Explore the nature of sexual and reproductive health services available to, and accessed by young married women.

In this section, I present both the health workers' and young women's perspectives on family planning services and access to contraceptives. I also discuss antenatal care and how women seek healthcare in pregnancy, and where they give birth. Monetary influences seem to play a crucial role in the advice given by health workers, as they usually favour tubal sterilisation, a practice that pays, and hospital delivery, yet another government incentive that pays.

5.2 #Objective I: Reasons for the Existence of Adolescent Marriage

In the prologue, I presented the story of Radha, a young married woman from Shivgarh. Radha's story is, in many ways, symbolic of the life of an adolescent bride living in a rural area of Uttar Pradesh. This story also tells the reader about the context within which early marriage takes place. Using her story and the stories shared by seven other young married women, I will present the reasons for why the practice of adolescent marriage is upheld despite being illegalised in India through the Child Marriage Restraint Act in 1929 (26).

Data analysis outlines two possibilities for the persistence of adolescent marriage in Shivgarh- socio-economic factors, where community members see early marriage as the only option, and cultural norms that favour early marriage. Socio-economic factors that lead to early marriage are lack of education, lack of knowledge regarding birth registration and biological age, lack of economic resources to feed many children and number of female children within the household. Cultural factors that favour early marriage are the views on puberty being a risky behaviour, pre-marital sex being the result of delaying marriage and negative views on sexuality on the whole.

Although their stories were different and complex in nature, the following traits were common all eight participants:

- No or limited level of clean water, toilet facilities and electricity at home;
- No or limited level of education;
- Spouses with no or limited level of education;
- Self and/or spouses unemployed, temporary manual labourers in local fields or migratory workers;
- All participants are very thin (no measurements of weight are taken, however);
- Six out of eight participants do not own a birth certificate;
- The same six participants do not know their actual age;
- All participants have either two or more female siblings;
- All participants belong the lowest social class;
- All participants are either low caste Hindu or Moslem.

Using the Platform for Action and the Beijing Declaration definition of poverty (55), it is clear that the participants are victims of poverty. This definition of poverty states that:

“Poverty has various manifestations, including lack of income and productive resources sufficient to ensure a sustainable livelihood; hunger and malnutrition, ill health; limited or lack of access to education and other basic services; increasing morbidity and mortality from illness; and social discrimination and exclusion”.

Thus, I will present how poverty is an underlining factor that leads to early marriage in these participants, and how the participants who are ‘victims’ of poverty, are also ‘victims’ of early marriage. In this discourse, I will emphasise on participants’ perceived notion of ‘not having a choice’, and how poverty comes to play in their lives and decides when and how they will marry. Poverty is manifest on many levels in these participants. Young married women participating in this study come from poor families with no or limited access to clean water and electricity; semi-built house⁹ or huts that are prone to being washed away in rainy seasons; and no toilet facilities within their households. The participants are very thin in comparison with their counterparts living in cities, and belong to the lowest social class within their community. Poverty as a concept will, therefore, be used in understanding how the participants reason why they do not have a choice, and how being poor leads to people not registering their children, not attending school and not knowing one’s biological age. Like in other studies, birth registration and lack of knowledge regarding one’s actual age will be seen as mechanisms of poverty (50;56;57).

An enquiry into the reasons for why early marriage still exists in Shivgarh despite being illegal, cannot bypass the importance of cultural norms that may facilitate early marriage. Thus, this analysis will present how cultural views on puberty, pre-marital sex and sexuality may lead to early marriage, and how the organisation of sexual relationships affects decision-making related to sexual and reproductive health of these participants.

⁹ A house that has either one or two rooms that have four walls and a roof, which are built using bricks and cement while other rooms are open rooms with no roof and are either entirely or partially made of mud.

5.2.1 *"I am poor. I have no choices..."-Adolescent Brides: Faces of Poverty*

"We had to do what our father told us to do. My sisters and I did not really have a choice. We are poor. Poor people do not have choices."

(Radha, 15 years old, married at 13)¹⁰

"Didi, we are poor people. What will we do? Poor people can hardly decide what they want. My family cannot pay for my education so what else is there to do for a young girl but to marry?" (Krishna, 15 years old, married at 14)

"I did not go to school after primary school because my mother could not afford my education. Getting decent education these days is expensive and we poor people do not have the money to go to a private school. You cannot just be a burden to your parents (...) It is not good for girls to be a burden. A girl has no choice but to marry. You cannot sit at home all day either".

(Faiza, 17 years old, married at 15)

The passages above describe the lives of three adolescent brides living in Shivgarh. They all express the notion of *not having a choice*. This concept is directly related to poverty, which seems to be the most prominent underlining factor for why participants perceive they do not have a choice, and why they marry early. This chapter follows a discussion on how poverty leads to a sense of 'not having a choice' in the participants, and how poverty is directly related to, if not responsible for, why girls are married off early in this population.

The participants give two main reasons for not having a choice- being a female and being poor. In the prologue, Radha tells us that her father is the sole bread winner in her family, and that although her sisters and she wanted to work and help their father, he did not consider this appropriate for unmarried girls. Radha explains that her father reasoned that people would start saying that he was not man enough to sort his own family out if he sent his girls to work. This became the main reason for why Radha got married. However, as Radha's father was poor and could not afford a big wedding, she was married in a poor family. This is also the case for all other participants.

Not having a choice can be read as a measure of hopelessness, where one has no other alternative but to succumb to the needs of the day. The need of the day, here, refers to doing what your parents tell you to do irrespective of your own wishes. It is the sense of not being

¹⁰ The ages presented here are approximations of participants' actual ages as they were not aware of their biological age. I discuss this in the chapter on biological age.

able to decide over one's own life that translates into getting married or not being able to attend school. Krishna expresses this by saying that *there is nothing else for a young girl to do but marry*. Radha articulates this lack of choice by talking about her dreams of becoming like the girls on film posters. These statements also tell us something about the roles attributed to men and women in this society, where if a girl does not attend school, she ought to marry. This rule, however, does not apply to men as they enjoy a certain liberty in deciding when they should get married. For instance, Faiza tells us that she is one of five siblings, and that she only has one brother. Her brother, albeit being the oldest, is not yet married. He has attended secondary school but dropped out of school when their father died. He needed to work to support his family as his father was the sole bread winner. Her brother is not married for two reasons:

“My brother has told us that he will marry only after our youngest sister is married off...he feels responsible for arranging money enough for her wedding...besides during the rainy season this year, the roof of our house fell down. We do not have a pucca (built) house and that makes it difficult for anyone to marry their daughter into our family... So he wants to build something before he can bring a wife home”.

The male child does not only become the primary source of income within the family in the absence of the father but also the official guardian of all female members of his family. He is, therefore, also at a liberty to wait longer before marrying. This finding is in compliance with the Indian (or Hindu) Adoptions and Maintenance Act of 1956, which states that a woman cannot ‘maintain’ herself, and is to be maintained by her father-in-law after the death of her husband, and by her son in the absence of both husband and father-in-law. The term maintenance, here, refers to economic dependability (58). Patriarchal line of responsibility also presumes that a male child will automatically inherit his parents’ property, leaving the girl child without major economic flexibility to make decisions of any kind. Whereas a girl child is traditionally viewed as an economic liability for the family in agricultural communities, a male child adds to the manpower of the family (3;59). These practices reinforce the inequality of women and strengthen the view that females can be exchanged or sold for the value they bring into the receiving families (2). The varying financial situation between men and women results in unequal relationships is said to have serious consequences on the power dynamics between them, where women’s decision-making power is either low or non-existent (2).

Returning to the notion of not having a choice, we asked Radha what she meant by not having a choice. She says that she does not feel she had a choice because she did what her father told her to do despite being unhappy about this decision. She says:

“I felt that I had to do what my father told me to do. I did not want to disappoint him but I cannot say that I was happy. I did not know who this person was or what he would be like but I guess one has all life to learn all this”.

She goes through with the wedding because she does not want to disappoint her father. Embedded within this decision is the perceived guilt of doing the right thing for the family, which in this case, is to get married. Radha tells us that she is obliged to do the ‘right’ thing because of her father’s life situation:

“The thing is that my Babu Ji (father) cannot afford having me at home. He is the only one who works in our family and I couldn’t be a burden to him. He just wanted me to have a better life so that I could live better. I understand that. Every father wants their daughter to be happy.”

Faiza tells us that a girl is an economic burden on her parents, and that it is not good to be a burden for a long time. That is why it is good for a girl to get married as soon as possible. The perceived notions of being a burden and doing the right thing become agents of early marriage. It seems as if girls are brought up to believe that they are an economic burden to their families until they are married. Studies on poverty and early marriage suggest that girls from poorer families are viewed as additional burden on family resources, and they tend to be married off earlier as a family survival strategy (35). This phenomenon is also discussed by Otoo-Oyortey and Pobi, who suggest that in traditional settings, poor families use the early marriage of daughters as a strategy for reducing their economic vulnerability by shifting the economic burden related to the care of a girl child to the husband’s family. This increases a family’s assets as they now have more resources to feed fewer mouths (2). Early marriage is, therefore, seen as the only option for girls where a family is very poor.

Marriage can also act as a dual exchange of price or wealth. As a new bride brings in money from her maternal to bridal home, she acts as barter in this marriage transaction. This is the main reason for why a family also wants to have more boys than girls. As daughter-in-laws bring in money to the family, having a greater number of boys is perceived to increase the family’s wealth. Having a girl, on the other hand, is not seen as economically beneficial as they will take family’s wealth with them. This exchange of wealth is called dowry, and it is

paid by the parents of the bride. The consequences of this dowry are greater for poorer and vulnerable sections of the community as they do not necessarily have the resources to provide a handsome dowry. Literature on dowry and early marriage suggests that parents of younger brides have to pay a lower dowry (36). This is due to the general demand of younger brides within rural communities as they are perceived to be 'purer' and more fertile than their older counterparts. The concept of pureness is related to their lack of exposure to their surroundings (2;4;35;36). Thus, it seems like a logical choice for parents to marry off their daughters at an earlier age due to the lower costs incurred as a result of lower dowry. Although this practice has both been documented and continues to play an important role in marriages, especially in rural India (4); it is important to note that the practice of dowry was abolished legally in India in 1961, when the Dowry Prohibition Act was passed (60).

I. Implications of Poverty:

The discussion above points out that poverty, as a factor, determines several things in the participants' lives. Further speculations as to how poverty manifests itself in the lives of these participants, one may suggest that their level of 'having no choice' is also present in their access to education and whether they will complete, at least, primary school if they have had some access to education before being married (off). Using socio-economic factors that determine levels of poverty, such as the type of house, our observations showed that our participants differed in their levels of poverty. Both Radha and Krishna were illiterate. Their parents did not own any land and worked as manual labourers in the village. Radha and Krishna lived in huts. However, Nafisa and Faiza had attended primary school and their parents also had some land. Their houses had, at least, one built room. Radha and Krishna were, therefore, classified as being poorer than Nafisa and Faiza. A study by Singh and Samara shows that level of education and early marriage are inter-related, where a girl who has attended secondary school is less likely to marry early in comparison with a girl who has not attended school at all (3). Moreover, number of female children per household has an effect on the likelihood of the children attending school as well (4). All of the participants had two or more female siblings each, where the siblings had either no or very little education. In the cases where the participants had an older brother, the age of marriage was delayed until after having reached the age of menarche. However, if the girls were older, they were married off either before reaching the age of menarche or directly after. I will come back to the different types of marriages in the following chapters.

II. Poverty and the realisation of young women's human rights:

Poverty has implications for the realisation of these participants' human rights. Research illustrates that being married off early as a result of poverty hinders the overall development of a girl child (2). Article 26 of the Universal Declaration of Human Rights states that:

- I. Everyone has the right to education. (...) Elementary education shall be compulsory. (...)
- II. Education shall be directed to the full development of the human personality and to the strengthening of respect for human rights and fundamental freedoms. (...)
- III. Parents have a prior right to choose the kind of education that shall be given to their children.

Keeping a girl away from education is, therefore, a violation of that girl's basic human rights. Elementary and lower-secondary school education in India is free of charge within the public school system. Thus, there is theoretically no reason why an individual should not be educated, at least, to this level. The National Policy on Education of 1968 refers to elementary education as being the fundamental right of every child, thereby, legally binding parents to send their children to school (61). However, girls who are married early are often denied access to education or taken out of school, which diminishes the possibility of the *full development* of their human personality and an opportunity to acquire critical life skills (4). In this study, we asked young married women if they saw any possibility of continuing their school education whilst being married. The common response was that this would not be possible due to familial responsibilities that are associated with being married. Madhoo, the only adolescent bride who is employed presently, said:

"My husband is ill, didi. This is the only reason why I work in the fields so that I can look after him. He does not have any brothers or a father who can take care of him. I also work at home, make food, and clean the house. I cannot see how I could go to school and study now".

Krishna responds similarly by saying that familial chores and having a baby are far more important for her as a daughter-in-law than going to school and getting a job:

"Oh...how will I study? My mother-in-law would like a small child in the house so that they can be happy with me. Education is no longer a possibility for me. It would have been if I was not married but right now the most important thing is to do what I am told to do by my mother-in-law and my husband in this house..."

These responses do not only indicate that the basic human rights of individuals living in such marriages are being violated but also the fact that early marriage is a hindrance in achieving the second Millennium Development Goal of achieving universal primary education (62). The National Family Health Survey-III data from Uttar Pradesh illustrates that 54% of women living in Uttar Pradesh have no education, and only 18% of women have ten or more years of education (14). This statistic poses a threat to the achievement of MDG II, which seeks to ensure universal primary education for all boys and girls by 2015. It would, therefore, not be an exaggeration to state that Uttar Pradesh will not be able to achieve the MDG II if girls are either left out of schools completely or taken out of school to get married early.

Eradication of poverty and ending extreme hunger (MDG I) is yet another target within the Millennium Development Goals Framework (62). Poverty, as discussed above, is an underlining factor in getting married (off) early. Furthermore, patriarchal structures within society and poverty lead to inequalities between men and women, where women do not enjoy the same economic freedom as men (37). This is characterised as a form of poverty that is manifest in the lack of human social capital as livelihood skills, education, interpersonal skills, good sexual and reproductive health and well-being (2).

It is important to note that poverty related early marriage also leads to the violation of the right to choose one's own partner when being 'full of age' or legally mature, as stated by Article 16 (I & II), in the Universal Declaration of Human Rights:

I. Men and women of full age, without any limitation due to race, nationality or religion, have the right to marry and to found a family. They are entitled to equal rights as to marriage, during marriage and its dissolution.

II: Marriage shall be entered into only with the free and full consent of the intending spouses.

Radha, Krishna and Faiza tell us that they were married off because they did not have any other choice. Early marriage was their only option and it was mainly their parents who decided what they should or should not do with respect to education and marriage. None of the young married women who participated in this study were 'full of age' in the eyes of Indian or international law, and although they consented to getting married, their consents were based more on the perceived guilt of doing the right thing than actually wanting to get

married to their spouses. For instance, Radha told us that she did not know her husband until she got married to him but that she knew that she had all life to get to know him. Radha's arranged marriage was, therefore, a violation to her right to choose her own partner. Although India is signatory to the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), the discrepancy between the legal minimum age of marriage and the actual age when women actually marry in certain social contexts, is due to the "official tolerance of cultural, societal and customary norms that shape and govern the institution of marriage and family life" (46).

The vicious circle of generations of women being denied their basic human rights with respect to marriage is upheld due to the prevailing social norms that make it difficult for women to annul their marriages, once they are consummated. According to the Prohibition of Child Marriage Act of 2006 (26), for instance, once a child marriage has been consummated, it is practically impossible to annul. This is so because a child involved in child marriage needs the signature of his guardians (parents) in order to file for the annulment of her marriage. As parents often are the ones who make decisions related to early marriage, annulment is not possible. Due to lack of education and knowledge of legal systems can also lead to individuals not realising their basic human rights. The participants of this study belong to a group of individuals who are not aware of the existence of any such laws or their basic human rights.

III. Poverty and its effect on participants' health statuses:

The discussion, so far, has been concerned with how the participants view themselves as being an economic burden to their families, how their access to the public sphere is restricted after having reached the age of menarche, and how this restricted access and patriarchal systems of wealth distribution lead to inequalities between men and women in their community. Ingrained within these issues is the question of how these mechanisms affect participants' health statuses. Phipps illustrates that the causal relationship between poverty and health is well-established within literature, and suggests that long-duration of poverty has negative impact on an individual's health (63). The participants of this study are individuals who have lived their entire life in poverty, and therefore, more prone to ill-health than individuals who have not lived in similar life situations. Phipps further outlines that on an individual level, the personal experience of poverty may be associated with poorer health

outcomes. In the participants of this study, this experience of poverty is best described by thinking that one has no choice. This notion of 'having no choice' refers to a perceived state of hopelessness, which, over extended time-periods, may lead to adverse mental health problems (64). According to the Hopelessness theory of depression, the feeling of hopelessness over an extended time-period alone is sufficient in the diagnosis of a subset of unipolar depressive disorder, namely hopelessness depression (64). The expanded hopelessness theory of depression, as described by Panzarella, et al., outlines that social support can protect against this type of depression (65). From what the participants tell us, it seems as if social support is conditional upon them being married off, something that may or may not be what they had initially wanted for themselves. Taking into account the hopelessness theory of depression, their sense of 'not having a choice' does not decrease over time simply by accepting that it is their destiny to get married early. Although some social support exists when a girl decides to go through with the marriage, she may still be in the risk zone for acquiring a hopelessness depressive disorder if her sense of having no choice continues.

Although no physical measurements were taken during my field visits in Shivgarh, I described participants as being thin earlier in this section. This concept of 'thinness' was derived after having been in the field for four months, where I had the opportunity to visit other cities and villages in Uttar Pradesh along with Shivgarh. Young married women who participated in this study were visibly thinner than their counterparts who reside in cities, and were equally thin visibly as their counterparts living in similar villages. Visible thinness of participants can be understood in many ways. National and regional estimates on body weight and nutritional statuses of men and women across India suggest that about 37.2% of ever-married rural women aged between 15 and 49 living in Uttar Pradesh have a body mass index (BMI) that is below normal, which means having a BMI less than 18.5 (14). In comparison with rural women, only 23.3% of ever-married urban women between the ages of 15 and 49 are clinically underweight. The National Family Health Survey-III also suggests that there is a direct relationship between body mass index and level of education, where those with no education have a lower BMI than those who have completed primary and secondary schools (14). As access to education is seen as a factor of poverty, one may deduce that poorer women are thinner. A study from rural Maharashtra, India suggests that young rural women are thinner because they do not feel that they can eat adequately due to a steep

increase in their responsibilities (8). Chorghade et al. suggest that when young women get pregnant, their access to essential staple foods, such as rice, is restricted due to the negative cultural notions of such foods making pregnancy and the delivery process harder for women (8). Radha tells us that as she is trying to have a baby, her mother-in-law has told her not to eat rice, green vegetables and *ghee* (Indian butter) because this will make the delivery of her baby more difficult. When asked why eating all that would make her delivery difficult, Radha says:

“In the village we believe that if you eat all these foods when you are pregnant, you get fat and your baby gets fatter. Fat babies are difficult to get out and then you may have a troublesome pregnancy...so we do not eat all these things when we are pregnant...As I am trying to get pregnant, my mother-in-law does not allow me to eat all these things.”

(Radha)

This cultural practice of eating less during pregnancy may pose a serious threat to an already thin woman's life. Kumar et al. suggest that home deliveries are very common in Shivgarh (40), and findings from their formative research suggest that villagers think that bigger pregnant women produce bigger babies, which leads to complications during delivery. Thus, this practice of restricting foods during pregnancy culturally serves the purpose of making the delivery process easier for a woman. This practice may, in fact, result in completely the opposite and a woman may suffer from complications or die precisely because she is underweight and malnourished. As mother's weight and nutritional status are directly related to the baby's health, this practice may lead to a higher level of morbidity and mortality in the neonate (40). Thus, it would not be an exaggeration to suggest that poverty affects the lives and health of these participants.

5.2.2 “I do not know when I was born...”- The Birth Registration Issue

“People give birth at home here in this village, didi...and then some people wait for months before they give their baby a name or even a year because the name has to be right...I have heard about birth registration and birth certificates but I do not know how this is done in our village...Most people do not care about it because it is not important...It is not like getting a paper will make my child’s or my life any better...it would not make much difference, really. What do I need a paper for when I do not know what it is for?”

(Devi, an adolescent bride)

Six out of eight young adolescent brides, who participated in this study, could not tell us when they were born. The other two participants, Nafisa and Faiza¹¹, showed us their hospital registration cards, with their age and date of birth. Upon asking, Nafisa told us that she did not have a birth certificate but that her primary school teacher had put an *auspicious* date on her school card to sort out her school registration requirements. Faiza told us that her mother had registered her and had her birth certificate.

In the passage above, Devi expresses that she does not see how obtaining a birth certificate will make a difference in her life. She also suggests that the name of a child has to be right, and that it is important to get the name right even if this process may take many months or a year. When asked why names are important and not a birth certificate, she suggests:

“The name has to be right because a good name will bring good luck while the wrong name will bring unhappiness and bad luck... The name has to come to you as a sign from God. The elderly people and Pundit Ji in the village know this and can talk to God...they are also helpful in finding the child’s name. Birth certificate does not bring you luck”.

Other participants express similar notions regarding the naming ceremony of a child. It seems as if birth registration and birth certificates are not important to the participants, and that they do not fit in with their cultural totems. The naming ceremony, according to the Hindu tradition, is the first ceremony that is held for a newborn baby. This usually takes place on the twelfth day after birth, as the first eleven days after birth are considered impure both for mother and the newborn. Where it takes several months or even a year to choose a child’s name, a temporary ceremony is held after the twelfth day, which serves the purpose of welcoming the child in the world. This naming ceremony does not necessarily have to

¹¹ The names have been changed to protect participants’ identity.

correspond to the official name given to the child, and can also involve a nick-name (1;57). A birth certificate, therefore, does not receive the same level of attention within this culture, and is merely viewed as a paper that has no particular significance, and cannot bring good luck. One may speculate that this is the case as birth certificates need to be issued before the 12-day mark, and as this does not fit in with the cultural practices of the participants, they do not give any significance to this document. Nafisa tells us that because she is Moslem, she does not follow the Hindu tradition but that her family asks the local Imam for which names can be used for the baby. This is done immediately after birth. However, the concept of a good or bad name is also of relevance to Nafisa.

The concept of 'good' vs. 'bad' is central in Indian culture, where good refers to religious and ritual purity, and bad refers to ritual pollution and defilement (66). The never-ending battles between good and bad/evil are frequent in Indian mythology, and the good element always triumphs over the bad (67). This is best illustrated in the folklore on Lord Rama, a Hindu deity, who is often described as the ideal man and is the hero of epic *Ramayana*. *Ramayana* is seen as the mirror of the highest ideals of Hindu culture and civilisation, where Lord Rama is the ideal man, ideal king and son, and his wife, Sita, is the ideal woman, ideal daughter, wife and mother (68). Good luck, therefore, is a concept that is closely associated with one's inherent 'goodness' of being. One's goodness of being is also related to the concepts of heaven and hell in Hindu mythology, and dictates whether one is born into heaven or hell either in the present or future lives (67). The 'rightness' of name-giving, is therefore, an important attribute because it can affect someone's luck either positively or negatively. Birth certificates do not enjoy the same status as names as the participants do not attribute either good or bad luck to them. Names seem to replace the significance given to birth registration as an individual's existence becomes valid from the twelfth day of his birth.

It is suggested that poverty places a major role in establishing who gets registered. Living in poverty, in itself is not directly related to people not registering after birth. It is the fact that poorer women are more likely to deliver at home (thereby not registering); less likely to attend antenatal care services (where women get registered); less likely to vaccinate their children (where children get registered); less likely to attend school (birth certificates are necessary for school enrolment); and less likely to be aware of what birth registration entails and why it is important that dictates individuals do not get registered in certain communities (50;57;69). As poverty is directly related to access to education, attendance in antenatal care

programmes, vaccination and immunisation, and knowledge regarding registration, one can say that being a victim of poverty may translate into not registering.

Nafisa, an adolescent bride and mother of one from Shivgarh, tells us that her school teacher had put an *auspicious* date as her date of birth on the school enrolment form. Birth registration and certificates are important for school entry in India. The concept of auspicious dates is also related to the concept of goodness and badness, where certain dates according to considered good or auspicious and attribute good luck according to Hindu mythology (67). Auspicious dates, here, however can also refer to dates that are perceived as being good by the school teacher and may not have a deeper religious root.

When asked whether it was common for school teachers to forge birth dates, Devi said:

“Yes, didi...this is very common in our society. If a parent does not have a birth certificate or if the person does not know how old he is, then the person responsible either makes a fake document that looks like the original birth certificate or people write a date that they think is good on the paper.”

Serrao and Sujatha discuss forging of birth registration documents or allocating random dates for one's date of birth as being one of the major barriers in the lack of quality assurance related to birth registration services (57). They suggest that teachers often put a child's date of birth in May, June or July because they do not have the appropriate birth certificates and the children's parents are not aware of when their children are born. The authors do not give a particular reason for why teachers choose these months. One reason can be that schools start in August and children born later than August have to wait for a year to start their education. By putting birth dates in May, June or July, the teachers ensure that the children can start their schooling early. Albeit a positive step for children's school initially, this leads to dissemination of incorrect information. It may also become an agent of possible discrimination against children who may be expelled from school earlier because they are 'old' enough to work according to their forged birth certificate or can be married earlier; they are now declared mature in the eyes of law. Serrao and Sujatha suggest that there is a need to ensure that birth certificates cannot be forged.

An interesting finding when discussing birth registration with health workers is their attitudes towards villagers. Their attitudes are of interest because they affect their interactions with community members either positively or negatively. Community health

workers are responsible for registering newborn babies in rural areas, and their opinion on the birth registration itself and low levels of registration can be of importance in understanding why people do not register their children. An ASHA, Malini, who has worked as a community health worker for the past two years, tells me that naming ceremony is very important part of a newborn's life, and although it is good to register one's child, it is not more important than giving the child a good name. Malini was not registered as a child but tells me that she is 27 years old according to her forged birth certificate, which took her a lot of money to get. From our interactions, it seems as if community health workers do not think that it is an individual's human right to be registered. Although the Anganwadi workers know that it is a government requirement to get registered, the ASHA do not know this.

Like Malini, other community health workers think that the villagers are *stupid* and do not know or understand *much*. This is the main reason why they do not register their children. This is a recurring theme both in this instance and in discussion on other practices. When asked why For instance, people in Shivgarh did not register their newborn babies, Malini says:

“Madam, the thing is that people here are from the village...They do not go to school, they do not know much. Village people are usually stupid, you know. If you cannot write your name even, how would you know other things?”
(Malini, an ASHA)

As villagers are considered stupid, health workers assume that they are not able to understand concepts such as birth registration. Anuradha, the only health worker interviewed in this study that does not refer to villagers being stupid, says that a reason for why people do not register their newborns is because there are no effective registration systems in place in Shivgarh. She has been working as an ASHA for the past two years and tells us that she does not know which of the community health workers should register newborns as their roles are not clearly defined. When I ask her about her training, she tells us that she received her training, like everyone else, at Shivgarh hospital and that it lasted for fifteen days. She tells us that she was not told when and how to register children during this training.

“It is difficult to know your age if you are not registered. We do not know who is really supposed to register people. The AWW didi is also responsible for registering babies but we are the ones who take the woman to the hospital so I do not know. It is both our jobs, which makes it confusing because you do not know who is really supposed to do what. I was not told in my training who should register babies, really” (Anuradha, a 30 years old ASHA)

When we ask the same question to Bhavika, who is an Anganwadi worker, a different type of community health worker from ASHA, she says:

“You see registering people is a problem. Not all of them show up at school and not all of them are there for the local vaccine days or nutrition days. Also, it is not just my job. It is ASHA ji’s job as well, you know. She is also responsible to do just that. I cannot run from home to home and register people because I simply do not have the time. There is only that much you can do in a day. We cannot both visit women at home and see if they are doing what they should do in pregnancy or see to newborn babies...and do all the rest. We just have too many targets to deal with...”

It is evident that the health workers do not really know which type of community health worker is responsible for birth registration. They also express that their roles on various levels are similar, and they do not always know which one of them has done what. They tell us that they belong to two different departments within the health system, and as such do not know which one should do what in the community. This is one of the problems that hinders newborns being registered, which is obligatory according to Indian Law (70).

Implications of these findings for the participants:

Birth registration has been considered essential because it is a permanent and official record of an individual’s existence and citizenship. Article VII of the 1989 United Nations Convention on the Rights of the Child (29), of which India is a signatory, states that:

The child shall be registered immediately after birth and shall have the right from birth to a name, the right to acquire a nationality and as far as possible, the right to know and be cared for by his or her parents.

This right is also enshrined in Article XV (I) of the Universal Declaration of Human Rights, (33) which states that *everyone has a right to nationality*, and in the Article 24, paragraphs

(II) and (III) of the International Covenant on Civil and Political Rights (71), which states that:

- II. Every child shall be registered immediately after birth and shall have a name;
III: Every child has the right to acquire a nationality.

These statements imply that an individual who is not registered at birth is in danger of being denied the right to an official identity, a recognised name and nationality (50). In principle, this means that an individual who is not registered does not exist in the eyes of law, and may face discrimination or lack of access to basic health and welfare benefits. As one's human rights cannot be rationalised until one is born, an unregistered citizen can be considered as a citizen who was not born in the eyes of law, and therefore might not be able to exercise his human rights. Alongside being important in the rights based approach to understanding human existence, birth registration is important for statistical purposes. Demographic data provides disaggregated data on the situation of individuals living within a community and leads to appropriate planning and implementation of policies and programmes (72). Potential programmes are not likely to reach the unregistered populations if governments are not aware of how many people potentially need schooling or healthcare or other welfare benefits. Unregistered individuals may, therefore, not be able to realise their potentially fully or may be marginalised and disenfranchised.

It is suggested that low birth registration is directly related to poverty in that poor people are less likely to get registered (50;57). This is because poor people are less likely to be educated and less likely to know the importance of birth registration. In Shivgarh, lack of birth registration seems to be generational, and there is a perceived lack of demand and importance in getting registered. Furthermore, there is also a lack of clear lines of responsibility for birth registration. The Registrar General of India estimates that only 11% of individuals are registered in rural areas of Uttar Pradesh (50). The findings of this study suggest that lack of perceived importance given to birth registration within community as well as health services at a community level in Shivgarh lead to low levels of registration. These findings are confirmed by other studies that suggest lack of quality assurance of registration methods, perceived lack of importance related to birth registration at a community level, societal emphasis given to choosing an appropriate name despite being

time-consuming, and lack of clear lines of responsibility in registering children in rural areas are the main reasons for why people choose not to register (50;57;70).

One may question as to how not being registered affects the participants of this study. On a more superficial level, one can say that birth registration does not affect the daily lives of young married women. Using a human rights approach, however, not being registered poses a threat to the exercising power of one's human rights as the right to nationality is the proof of one's existence in the eyes of law. Thus, if one does not exist in the eyes of law, one is not able to exercise any rights either.

From a public health perspective, birth registration is of utter importance for a number of reasons. For instance, birth registration is of significance for vaccination purposes. As vaccines are age-specific, it is important for a child to gain the age-appropriate vaccines in immunisation management (69). If a child is not registered at all or registered late, this can cause problems for her health (57). It can, therefore, be assumed that by registering a child, it is more likely for this child to gain vaccines. In an Indian context, where female infanticide and female foeticide are frequent, accurate registration of babies may help decrease the rate of murder of the female neonate (73). Birth registration is important in the implementation of national policies and health interventions, and can be used as a tool to protect children against child labour, child exploitation, premature enlistment in the armed forces, being falsely prosecuted as an adult, or as in study, being married early (56).

5.2.3 *“I do not know how old I am...but I feel old enough”*- The Biological Age Issue

Embedded within the concept of owning a birth certificate is the knowledge of one's biological age. One needs to know one's age in order to gain a passport or gain access to education or healthcare. One may, then, presume that having a *right to nationality* is dependent on knowing one's biological age. Just like with birth registration, not knowing one's biological age can be related to poverty as it can be seen as a product of lack of knowledge and lack of access to education.

Six of the eight young married girls, who participated in this study, did not know their biological age. When asked how old they were, their most common responses were:

“I do not really know how old I am, didi...I think I am quite old, though. I feel old. I know that my sisters are older than me because they married before me...but I cannot be sure as to how old I am really.”

(Saira, resident of Shivgarh and married)

“I think I am older than 40, didi. I am married, I have just had a kid but I am not sure. I think my brother must be around 50 years old. You can ask my mother-in-law...she must know how old I am, I do not think I do”.

(Pooja, resident of Shivgarh and married)

“Why do you need to know my age, didi? Age does not matter when you live here in the village but you can ask my mother-in-law, she may know”.

(Devi, a young mother of one and married)

The participants explained the concept of age as being ‘old enough’, which is a feeling rather than an accurate description of biological age. Age was also conceptualised according to the perceived notion of others' age. Pooja and Devi told us that we could ask their mother-in-laws about their age. Overtly, one may presume that it is the mother-in-laws who are in-charge of any important information within a given household. During our interviews, if a mother-in-law disturbed the interview, the young married woman would continue her answers by saying:

“Didi, please ask my mother-in-law. She knows best.”

This statement is, perhaps, much more a statement that reflects power structures within a household rather than the mother-in-law's competence in knowing what is *best* or everything. These power structures are discussed further in the chapter on how decisions

related to sexual and reproductive health are made. The notions of being ‘old enough’ and asking the mother-in-laws about their daughter-in-law’s age were explored further. Saira told me that she became old enough when she reached the age of menarche.

“Didi, there are certain things that mark change in your life. You are a young girl and then when you have your hair washed (Indian term for menstruation), you become old enough to get married and when you are old enough to get married, you are old enough to be a responsible person”. (Saira)

For Devi, being old enough did not only mean that she had reached the age of menarche but also the fact that she was married and had a baby. The respondents viewed becoming ‘old’ and ‘old enough’ as an evolving process, where having a baby was a step further in this transition. Madhoo, who had given birth to a disabled child that died two days after birth, said that she felt older because she had now lost her baby. Her sense of being older after the death of her baby was related to her grief she experienced after the loss:

“You grow up when you get your period and then your parents marry you. When you are ready to marry, you are old enough...and then you produce children...but my baby died and I am sad. Sorrow makes your hair grey and sorrow makes you older.” (Madhoo)

The passages above illustrate the way the participants viewed their lives in terms of age. The concept of ‘age’ is divided into either being young or old (either in terms of oneself or others), where the level of ‘oldness’ is defined by how many rites of passage an individual has completed successfully. Rites of passage, here, are related to certain events in one’s life- birth, age of menarche, marriage, motherhood (and in Devi’s case- losing a child), becoming a mother-in-law, and so forth.

As the concept of biological age was important for this study, two different techniques were used to deduct participants’ close to true biological age. Mother-in-laws were asked where participants wanted us to do so. Age autopsy (this is discussed in methods) was used in addition to asking the mother-in-laws. Pooja’s mother-in-law, Bimla told me that Pooja was four years younger than her son and that her son was about nineteen:

“My son is 19 years old. I remember this day clearly as it was the happiest day of my life. Pooja is about four years younger than him. It was Pooja’s mother who thought that she was around that age... I am not sure if it is four years or more but it cannot be less because Pooja’s parents are our neighbours and I have known them for a long time. We people who live in the village do not really know how old people are. It does not matter to us”.
(Bimla, Pooja’s mother-in-law)

This statement tells us how biological age is calculated in Shivgarh. It is related to certain events rather than the exact date of birth. This reiterates the cultural significance given to certain events in one’s life, of which birth is a part. In order to ensure that we interviewed individuals in the “correct” age group for the purpose of this study, age autopsy was used. Participants were given certain questions that could place them in age categories. These questions were relevant to Indian settings and are described in the methods section.

Reflections and implications of these findings:

I. Reflections:

When planning this study, I presumed that knowing one’s age was something intuitively obvious. The presumption of knowing one’s age being a universal construct, which is self-evident and important to all, was embedded in this rationale. The WHO categorisation of adolescence and young people, which is limited by age, was used as a basis for this study, and the cultural value of age in rural India was not considered. In hindsight, discussing the concept of age with the participants was an eye-opener for me as a researcher in understanding how constructs that I considered ‘obvious’ had coloured my perception. This reiterates not only the fact that a researcher’s standpoints play an important role in deciding what to ask and why but also the fact that one is a subjective reader and interpreter of others’ truths.

The concept of biological age is correlated with gaining higher levels of insight into one’s own and other’s emotional and social worlds. For instance, developmental biologists and psychologists suggest that a child’s brain, and thereby, understanding grows as she grows older. She acquires language and mathematical skills; a theory of mind, which enables her to understand the world around her (74). However, this is not the case for the individuals participating in this society, whose understanding of age revolves around the notion of progressive oldness. Although they give certain explanation related to the physical aspects of

getting older (menstruation, childbearing, grey hair); their understanding is mainly centred on rites of passage and not the biological quantification of age.

This interpretation of age is not unique to the peoples of Shivgarh, however. This construct is also used in Western cultures, where one operates on the legal (or biological) ages for when one is declared mature in the eyes of law to partake in a certain activity (legal age of having being 16 in Norway or being able to vote at the age of 18) and the cultural ages where one is old enough to understand certain concepts or is old enough to start taking more responsibility. The stage-like description of age, as discussed by the participants of this study is also present in most cultures where rites of passage mark a shift from childhood to adolescence to adulthood. Bar Mitzvah, confirmation, the Russ celebration in Norway are all examples of ‘coming of age’ that mark transitions from being young to becoming older. These transitions are celebrated through religious and cultural ceremonies. These transitions are also documented widely in literature. This is perhaps best illustrated by William Shakespeare in Jacques’ soliloquy on “All the world is a stage” (Act II, Scene VII, 139-166), which describes man’s life in seven stages from infancy to death (75). Returning to the Indian context, a man’s life is divided into four stages- *bramacharya* (the celibate student); *grihastha* (married family man); *vanaprastha* (hermit- abandonment of all physical and sexual pleasures); and *sannyasa* (total devotion to God and distance from everyday life) (76). Stages of life according to Hinduism, however, are traditionally only defined for men. Traditionally, women have not taken part in the bramacharya stage of life and been confined to homes, where they are responsible for household duties. This suggests that education of women, conventionally, has not received equal attention as male education.

II. Implications of these findings for the participants:

In a discussion on biological age, it is only natural to ask what difference it really makes for the natives of Shivgarh to know their biological age. Using a culturally-relative approach to understanding the concept of age, it does not make much of a difference to the lives of these participants to know their biological age. Not only that the participants give logical explanations as to why they do not value biological age, they also provide us with rich information as to why event-based transition is important for them. As discussed in the previous section on birth registration, the concepts of birth registration involves the right to nationality. On the same level as being unregistered can marginalise individuals and make

them invisible in the eyes of law; not knowing one's age can contribute to exploitation and discrimination of children. For instance, early marriage (marriage before the age of 18 for women and 21 for men) is illegal according to Indian Law (26). In the case where an individual is not even aware of one's biological age, one is most certainly not aware of the fact that one is committing a crime according to Indian Law. The participants of this study belong to this category of individuals. In order for an individual to know their biological age, they need to be registered, and in order for them to use Indian Law or the Human Rights, they need to be aware of the content of these laws and rights. In the case of early marriage, one needs to realise that one is, in fact, an adolescent bride. Where the concepts of early marriage and adolescent brides are alienated in this society, the Human Rights of young married women living in early marriages cannot be practised.

Thus, in answering the question of what implications not knowing one's real or biological age and date of birth have on young married women who participated in this study; it is not difficult to note that their basic human rights are being violated. However, this law can only be used when the individual knows about one's age, and is aware of the law. This is not the case for the participants of this study.

5.2.4 “*Bal Dulahi, gaun, ashudh sambandh- the uneven road to early marriage*”- What aspects of cultural practices in Shivgarh lead to early marriage?

1. **Bal Dulahi and Gaun:**

“Even if my wedding ceremony took place some years ago, I only moved to my husband’s house some months ago when my gaun (move from maternal to bridal home) happened. Nowadays if you get married before bal dulahi (washing of hair; local term for menstruation), you have to wait until you get your first period to move to your husband’s house. In my mother’s days, it was customary to move to your husband’s place just after your wedding day.”
(Sita, a 15 year old adolescent bride)

The significance of ‘bal dulahi’ and ‘gaun’ is proverbial in every young girl’s life in Shivgarh. ‘*Bal dulahi*’ or washing of hair is a local term for the commencement of menstruation. *Gaun* or movement from maternal to bridal home is the last ceremony that takes place in a traditional Hindu wedding. Moslems living in Shivgarh have also integrated this aspect of Hindu culture in their wedding rituals. The process of early marriage is divided into two ‘movement’ ceremonies. They depend on whether a girl has reached the age of menarche prior to marriage. If the girl has already had her first period, her movement ceremony occurs simultaneously as the official wedding. However, if the girl has not yet reached the age of menarche, she continues living with her parents until she has had her first menstruation. Her ‘gaun’, then, takes place when puberty has been attained, and she is sent off to her husband’s house.

Shivgarh is a patriarchal society, where individuals follow a patriarchal lineage of descent, where individuals live in their patrilocal residences, and where men inherit property. A patriarchal descent is reinforced by Indian law, which points out that a woman needs to be maintained by her father before marriage and by her husband after marriage (58). Thus, a marriage for woman living in Shivgarh naturally entails a move from her father’s house to her husband’s house.

These marriage rituals can help describe the significance of puberty in early marriage, and why the practice of early marriage is both culturally acceptable, and upheld despite its illegal status within legal frameworks. Although consummation of their marriages was postponed until the age of menarche, five of the eight young married women who participated in this study married before attaining puberty. For instance, Sita tells us that her wedding ceremony

took place some years ago but that she did not move to her husband's house until a few months ago. The participants told us that reaching the age of menarche was seen as a transition from childhood to adulthood in their community. As noted in the chapter on age, rites of passage determine one's feeling of oldness and status in the community. Menstruation is a sign of getting older, which signifies that a girl is no longer a child and is now fertile:

"When you get imsee (menstruation), this means that you are getting older. You are now a woman, you are now older..." (Radha)

"When you get imsee, people think that it is bad for you to go outside the house...this is because it is so risky. There are so many things that you cannot do once you get your period. People are afraid that you will go get pregnant before getting married...so if you stay at home, you are safer." (Saira)

The cultural understanding of puberty, the stage where one is old enough to get married, and the perceived danger associated with being sexually active before marriage are the main reasons why people marry early in this community. As soon as a girl is considered culturally fertile and old enough, her mobility is restricted and she is confined within the household. Saira tells us that people in her community think that it is risky for girls to go outside their house once they have had their first period. This is because of the perceived fear related to a girl being promiscuous as soon as she has reached puberty. Puberty is understood as a stage where carnal desires arise; desires that are only acceptable within the institution of marriage. Puberty, thus, presents certain risk factors, which are closely linked with the community's views on sexuality, pre-marital sex and honour of the family, which are discussed in the following section. The perceived risk factors are initiation of sexual activity before marriage with pregnancy and defaming of the family as outcomes.

A plethora of research body discusses how puberty is used as a control mechanism in various societies in restricting women's access to the public sphere. Singh and Samara suggest that these types of restrictions lead to exclusion of women both within a family and in public places, something that indirectly into women becoming victims of social poverty (3). This type of poverty proves disabling for a woman in, for instance, being able to realise her potential fully, in exerting control over her financial situation, and in deciding what is best for her. Jejeebhoy notes that restrictions on a woman's mobility due to conservative viewpoints on sexuality do not lead to disempowerment but also limit the extent to which

women can exert control over their own lives (11). She studies the definition of women's autonomy within the family in Uttar Pradesh and Tamil Nadu, and assesses the extent to which culture and regional ideologies influence women's autonomy in these two provinces. Her rationale is that despite similarities in poverty statuses within these provinces, there are huge differences in social development levels. For instance, women's literacy rates are higher in Tamil Nadu, and fertility and mortality rates are much lower than Uttar Pradesh. Her study concludes that it is precisely because of the level of power and self-control exercised by women in these provinces that lead to varying social and development outcomes. She argues that women in Tamil Nadu exert a higher level of control when it comes to self-mobility. They are able to visit more places either on their own or with other women in comparison with women living in Uttar Pradesh. Women in Tamil Nadu are also more likely to make decisions related to their health on their own, which leads to a lower level of mortality and morbidity within this population. Thus, cultural understanding of higher risk associated with puberty leads to an adverse outcome in the social development levels of women (11). This comparison is also essential to understand how social and cultural norms vary across India, and how one cannot generalise that what applies in Shivgarh, Uttar Pradesh will also apply in rest of India.

A study focusing on trends in the timing of first marriage among men and women in the developing world suggests that it is the perceived level of 'worry' associated with reaching the age of menarche that leads to early marriage (7). This perceived level of worry refers to parents worrying about their children becoming pregnant outside of wedlock, which depends on the cultural understanding of an individual attaining sexual maturity at the attainment of puberty. The perceived of sexual maturity, therefore, becomes the main motivation why parents choose to marry (off) their girls early. The perceived worry is directly related to the perceived shame associated with the perceived alternative, which is socially unacceptable. It is also suggested that parents exercise this fear and worry only for the girl child, and boys enjoy a greater freedom of movement (5;11). This again reiterates the fact that this fear is mainly associated with young girls becoming pregnant outside of wedlock. It also indicates that if a girl becomes pregnant outside of wedlock, she is the one who is blamed and restricted from cultural practices. I will explain this in the next section. These levels of fear and shame are also described by MacIntyre on his study on married adolescents globally (6). He suggests that these trends are more common in poorer parts of developing countries,

where individuals have no or less than six years of education. In his analysis, the fear associated with puberty poses a threat to a girl's chastity and her 'marriageability'. (6).

In short, early marriage is seen as an effective way of manage the risk of puberty, and for parents to 'get rid of' the problem before it arises. One may speculate as to why precisely this strategy of risk management is most commonly utilised, and why parents do not encourage their children to practice safe sex or provide children with education so that they can make better and informed choices. Some explanation might be that it is because the culture itself rejects the notions of pre-marital sex or that people have misconceptions related to how one can get pregnant or how appropriate sex education is a vital tool in making informed and better choices related to one's sex life. It seems as if these rejections are generational in Shivgarh, and that although contraceptives exist, they are not seen as an option for unmarried women. This social rejection of pre-marital sex and high risk associated with attaining puberty become the agents of early marriage and help uphold this practice from one generation to another. In the following section, I will present young married women's and health workers' perceptions of pre-marital sex.

II. Ashudh Sambandh- The story of pre-marital sex in Shivgarh:

The local terminology for sex is '*sambandh*', which translates into relationships. The participants refer to sex as being a sambandh between a man and woman, most often between married couples. This sambandh is considered '*shudh*' or pure as this relationship is tied by a heavenly knot that, according to Hindu tradition, lasts for seven lives. Men and women walk around the fire (*agni*) seven times to signify having married each other for seven lives. The notion of seven lives corresponds to the existence of seven heavens, one in each life. Thus, marriage is seen as a life-long commitment, which extends to seven different worlds. Marriage is essential within in a traditional Indian family and is considered to be the most important social custom (77). Pre-marital sex is described as '*ashudh sambandh*' between a man and a woman, where the word ashudh means impure. This means that villagers operate on two types of sex-one that is pure (between husband and wife) and one that is impure (between unmarried couples). The concepts of gaun and '*kanya daan*' in Indian tradition, is central to the understanding of fear and shame associated with engaging in pre-marital sex. Kanya daan precedes the gaun. Kanya daan translates into the ceremony

of donating of a virgin, and is seen as the most precious gift given from a girl's family to the groom, where a groom is supposed to promise financial stability, morality and sexual fulfilment to his bride. The concept of kanya daan, according to the marriage ritual, should only be used in the first marriage. A woman who remarries is not allowed to participate in this ritual twice because she is no longer a virgin. This ritual also implies that a woman should remain virgin until she marries. These religious rituals are part of the everyday life of the participants, who believe these traditions to be the will of God. Gaun is, therefore, the movement of a virgin from maternal to bridal home.

In the previous section, I described how puberty is considered an appropriate time to marry (off) girls in Shivgarh. Pre-marital sex, as a result of attaining puberty, is seen as a risk factor that becomes the driving force in early marriage. Here, I present how young married women and health workers view pre-marital sex and relate it to marriage in Shivgarh. Krishna told us that not all of her friends were married. These were often girls whose parents could afford to send their girls to school or girls who were waiting to find an appropriate match:

“Not all of my friends are married, didi. Some of them are waiting to be married; some go to high school...people tell me that those who go to high school are having affairs with boys. One of my unmarried friends got pregnant. She just brought such shame to her family...They emptied her stomach the other day (abortion)...and now she is not allowed to go out...if she had married, she would have it easier. My parents told me that such things can happen to you if you do not get pregnant...A girl should get married and then do all these things...”

(Krishna, a 15 year old adolescent bride)

This illustrates that going to school is related to being promiscuous, and can explain why parents keep their daughters away from school. When asked why her friend had ‘had her stomach emptied’ and not kept the baby, Krishna told us that having a baby outside wedlock was not something that people did in her community. She also told us that the parents of the boy, who had impregnated her friend, had refused to take responsibility if her friend had a child:

“They told her that the child had nothing to do with their son, and that she was lying about the pregnancy so that she could give a bad name to their son. Her parents could not do much because she had ruined their reputation in the community already. So, they decided to get her stomach emptied...”

Abortion was legalised in India some thirty years ago, when the Medical Termination of Pregnancy Act was passed in 1971 (78), and is permitted in the cases where it is essential in saving the life of a woman, preserving the physical and mental health of a woman, in the cases of rape or incest, foetal impairment, and for economic/social reasons. However, abortion is not available upon request. Krishna's friend, although safe-abortion was an option for her, chose to have her 'stomach emptied' from a traditional birth attendant, who is not medically trained. Krishna told us that her friend had done this because she had no other choice:

"Didi, it is not like the health workers could just take her to the hospital. They told her that she needed to bring her husband with her so that they could talk it over with the husband. They also told her that she had been immoral and that she just got what she deserved...So, my friend's parents decided to go to the Dai (traditional birth attendant), who did not ask many questions because she has seen such cases before..."

This illustrates how pre-marital sex and pregnancy outside of marriage are viewed by community members and health workers in this community. In the eyes of law, Krishna's friend had all right to go to the healthcare providers and seek safe-abortion. However, due to negative attitudes of community members as well as judgmental and moralistic attitudes of abortion providers towards pre-marital sex and pregnancy outside of wedlock, a legal abortion was not available to Krishna's friend.

A global report from the WHO states that nearly 20 million unsafe abortions take place each year; 98% of them in developing countries (79). A WHO study from India suggests that 6.7 million abortions are carried out by unauthorised health personnel (in most cases traditional birth attendants) in India yearly (80). Chandiramani suggests that unsafe abortions occur in rural women, who do not have access to 'fair' sexual health services. She argues that these women become victims of negative social attitudes towards sexuality and do not possess control over their own body (5). Fair sexual health services, here, refer to non-judgmental and non-moralistic health services that uphold confidentiality of the patient whilst giving appropriate health services. Krishna's friend is a victim of such negative attitudes, and has to go through with an unsafe abortion because she does not see any other choice. I will come back to the issue of autonomy over one's own body in the chapter on decision-making related to sexual and reproductive health.

Devi, now a mother of one, told us that she knew of a girl who had become pregnant outside of marriage, and how her family had disowned her. This did not seem like the most shocking thing for Devi, who told us that this girl was *beshareem* (defamed), and that she got exactly what she deserved:

“What can you expect when you do such gandi (impure; bad) things? You cannot really expect your parents to say that it is completely ok that you go out and sleep with a boy you are not married to; that is just wrong...She should not have done this. She got what she deserved...” (Devi)

In Devi’s opinion, a girl should wait until she is married to have sex. When asked why a girl should wait, she says that pre-marital sex is *paap* (sin), and that girls who engage in such activities are not *shudh* (pure). It is also justified that a girl who commits this ‘paap’ gets ostracised from her family, and cannot marry in future. This negative attitude towards pre-marital sex is generational, and is socially imprinted on the minds of both victims of social oppression (young girls) and the agents of sexual oppression (parents, husbands, in-laws, healthcare providers). I label young girls as victims of sexual oppression because it has been suggested that they do not see any choice when they become pregnant outside of marriage. I label parents, in-laws, husbands and healthcare providers as the agents of this oppression as they are the ones who control a girl’s sexuality (5;79-81).

When we ask health workers about pre-marital sex and importance of sex within marriage, most of them agree that sex belongs within the institution of marriage. The common notion is that pre-marital sex should be restricted and discriminated against because it makes boys and girls immoral in character. They also share the notion of pre-marital sex being a sin, and thereby, leading to individuals not being pure. In the group interview with health workers, we are told that one of the health workers had taken a girl to the traditional birth attendant to get an abortion because the girl had not told her parents about this:

“Madam, it is a shameful thing but I want to tell you that the other day I took this girl, who came up to me and told me that she had been knocked up by her neighbour’s boy, to the Dai because she wanted her stomach emptied. Obviously we could not tell her parents about this because they would either kill her or disown her...and obviously we could not take her to the local hospital because people talk. Everyone talks and then the community finds out. So the safest option is to go to the Dai and give her some extra money so that she shuts up. I do not how the girl got the money but she managed. Thank God, she did not die but she bled a lot...” (Malini, an ASHA)

The passage above is a testimony for two things- health workers' attitudes towards patients (people talking) and the difficulty in protecting an individual's confidentiality (community members finding out). It is also a testimony for why young women in rural communities choose to seek help from traditional birth attendants. During our observations, we found out that the Dais belong to the lowest caste within a community. A dai is usually an old woman who gets some money to assist with home deliveries and when someone needs an unsafe abortion. Although she is considered rural women's pregnancy doctor, she does not enjoy a high status in the community. Essential decisions in a woman's life, therefore, fall on the hands of someone who is not trained to carry out abortions or deliver babies. When we ask Malini what kind of advice she gave this girl after she had had an abortion, she tells us that she condemns her having sex before marriage, and that she tells her to stop living like this:

“Well, didi, I told her that she needs to stop having sex with that boy...that she should abstain from sex. I told her that I condemn this practice and that it is only an indication of her immoral behaviour. She will ruin the name of her family and bring shame to them. I told her to stop these shameful acts or I will tell her parents what she has done...”

In other words, Malini threatens this girl that she will tell her parents about her sexual activities. The main advice from her side is that she should abstain from sex, as this is an immoral behaviour for someone like her. This shows that the community health workers, albeit they help girls who need help by taking them to back alleys and getting unsafe abortions, are part of a society that preaches high sexual morale. Abstinence before sex translates into being pious, pure and virtuous, and engaging in sexual practices makes people immoral and *beshareem* (defamed). Every year unqualified health personnel conduct about 6.7 abortions. Dissecting this figure, one finds out that most of these unsafe abortions occur in rural areas, in young unmarried girls who go through with abortions because they do not feel that they have another choice. These abortions are either forced upon girls by their parents or considered due to the self-felt shame related to being classified as defamed (5).

It will, therefore, not be an exaggeration to suggest that abortions are used as the primary contraceptives by young men and women in rural communities. Upon asking the health workers what type of advice they give to unmarried girls who engage in sex before marriage, we also ask them if they offer them any contraceptives. Community health workers have access to contraceptives, such as condoms and contraceptive pills, and may also get contraceptives from the local hospital to distribute in the community:

“(Everyone laughs when we ask whether community health workers give out contraceptives to unmarried girls who come to them for unsafe abortions...). Didi...Are you nuts? If someone found out that we did that, they would kill us. Besides young unmarried girls should not have sex before marriage...they do not need contraceptives. Only women who have had a few children need contraceptives so that they do not give birth to a lot of children...so we do not usually give contraceptives either to young unmarried or young married women...Young married women need to have babies anyway...so they do not need the contraceptives either... (We ask if everyone agrees on this matter and all health workers nod and confirm this)” (Nandini, 30 years old ASHA who has worked as a CHW for the past two years).

This illustrates that although community health workers have easy access to contraceptives, they choose not to provide young women with them due to their negative attitudes towards pre-marital sex. Moreover, health workers fear that they will get beaten if they start distributing contraceptives freely in the community as this would be against their cultural notion of purity. I will discuss the use of contraceptives in a greater detail in the chapter on family planning.

We discussed the concept of their being a gap between actual wedding ceremony and movement from maternal to bridal home. This period can last everything from a few weeks to a few years. As five out of eight young married women in this study had got married before they reached the age of menarche, we asked them whether they could now freely move about in the village as they were now spoken for and would, potentially, not get harassed by other men. Sita said that her getting married had not had any positive effect on her mobility:

“I do not know about others, didi but in our family, you cannot see the husband until your gaun has happened. You are also restricted in the sense that you can no longer go out freely and play with village boys and girls. You are now married and must act like a married woman”.

Where Sita's encounters with her husband prior to gaun are restricted, other participants told us that they are allowed to interact with their husbands freely before the gaun ceremony as well. This means that once the wedding ceremony has taken place, some parents feel that it is secure for a girl to meet her husband-to-be. When asked why this is the case, Saira tells us that it is because parents are no longer worried about her being promiscuous:

“Although it is different for everyone, my parents did not think that it was problematic that I met my husband before I moved to his place. I mean...it is not like I met him every day. We met each other in social settings and it was acceptable for us to talk.” (Saira)

“You ask me why they let me meet him...well, because they were not worried that I was going to do anything bad anymore...I mean...I got married and I was only seeing the man my parents had chosen for me. It is not like we lay in the same bed...but we saw each other when my parents met his parents during the festival season”. (Saira)

Thus, early marriage of a girl, where the girl has not reached the age of menarche, acts as an additional protective mechanism of a girl's virginity. It is thought that once the girl is married (off), she is no longer in the danger zone for getting involved with anyone else. Sita, on the other hand, is not allowed to meet her husband-to-be before the actual movement ceremony as her parents do not consider it appropriate for her to mingle with him before the ritual ceremony. This indicates how marriage ceremonies act as controlling mechanisms of a young girl's sexuality.

Digging deeper in what Saira tells us, one can suggest that parents marry their daughters in the fear of their daughters becoming promiscuous. Marrying off girls early, therefore, acts as a solution to this problem. A newspaper article from Womensphere illustrates this same fear in Northern Nigerian population, where early marriage is common (81). The article points out that more than half of all girls living in this region marry before the age of 15. Long-held cultural values and poverty become the main factors in early marriage. The article presents the case of an Imam, a state judicial reform commissioner in the province of Jigawa in Northern Nigeria, who says that even if the government decides to enforce the age limit of 18 years for marriage in his province, the people of his province will defy it because it is better to marry off your daughter and go to jail than to have a grandchild outside marriage. This illustrates that the fear of girls getting pregnant outside of marriages is tour de force behind parents' decisions of marrying their daughters early.

In order to bring a comparative point into this discussion, I have followed an online debate that provides sexual advice to young Indian men and women. Dr. Watsa is a self-proclaimed sex expert or 'sexpert', who answers questions that men and women may have regarding sex. His column is very popular amongst young couples in Mumbai and is featured in the online version of Mumbai Mirror (82). This column can be openly accessed by anyone who is

online. The young men and women who ask sex-related questions are normally Indians who live in cities (mainly Mumbai), speak English and have access to the internet. Thus, they are very different from the participants of this study, who do not have access to the internet, who live in rural areas, do not speak English and have no or little education. The purpose of bringing in this comparison is to illustrate the level of misconceptions related to questions related to sex that also exists in an Indian population that is overtly very different from the participants of this study. For instance, a reader asks Dr. Watsa the following question:

“My partner showed me how guys masturbate and he accidentally ejaculated in a water tub. I used the same water to wash my vagina after urinating. Now I am worried. Could I get pregnant because of this?” Posted on Friday, May 08, 2009 at 02.13.25 AM

Another young individual writes the following:

“I am a 25-years-old unmarried woman (...). I can often feel strong physical urges and cannot stop myself. I put a pillow between my thighs and rub the area. Sometimes I can also get aroused in the middle of the sleep. A friend told me that doing this can break my hymen and can lead to loss of virginity. Please suggest some pills I can take to stop behaving like this. Can I break my hymen by rubbing with a pillow?” Posted on Thursday, May 07, 2009 at 02.19.35 AM

These two queries are only fraction of what men and women ask Dr. Watsa on Ask the Sexpert advice forum. However, these queries illustrate something very interesting. First and foremost, the concept of losing one's virginity prior to marriage (in the case of second post), and getting pregnant (first post) are commonly held fears even in educated population that has access to modern information technology and healthcare. This also illustrates that pre-marital sex remains a taboo even in urban populations that worry about getting pregnant or losing their virginity. Furthermore, knowledge as to why and how one gets pregnant or loses virginity is also scarce in urban populations. This may illustrate that level of education may not automatically translate into knowledge regarding sexual behaviours. Mensch et al. discuss that this is especially the case in Southern Asia, where although education is on the rise, early marriage and sexual taboos still prevail (7). What this does mean, however, is that there is a clear lack of sex-education within schools, where children are taught about the physiological as well as psychological aspects of being sexually active. One may suggest that the level of query becomes more sophisticated with education as urban men and women know about hymen, oral sex, and the purpose of ejaculation. In the next chapter on married

lives, I will describe how rural women from Shivgarh reason what is important in being sexual.

To conclude this point, it is only fair to assume that negative societal attitudes related to pre-marital sex leads to further segregation and discrimination of women. They are also violations of these women's sexual and reproductive health rights that suggest that every individual has the right to a satisfying and safe sexual life. The right to health does not describe this right to only be a function of marriage, and is extended to children as well as adults. Sundby suggests that negative attitudes, such as 'sexual pureness of girls' is of great cultural importance in marriages in some parts of the world, where marriageability is associated with one's virginity (21). In the right to marry, the 'consenting' marriage can be extended to individuals living in consenting sexual lives, where they themselves decide whom to have sex with, and how. This element is also present in the right to health. Thus, by limiting young people's sexuality, parents are not only violating their human rights but making their children more susceptible to risky behaviours, such as unsafe abortions or unsafe sex, which may, in turn be pernicious to their health (41).

5.3 #Objective II: Describe young married women's perspectives on their married lives

The last chapter discussed reasons for the existence of adolescent marriage in Shivgarh. This chapter will present how young married women view their married lives. Although the term married life implies two things – a shift in responsibilities from being unmarried to being married, and being sexually active; I will only discuss the first in this section. Being sexually active will be addressed under the context within which sexual decisions are made.

5.3.1 “*Being married is... being obedient to your husband...*”- Young married women's perspectives on being married

“You ask me what has changed in my life from when I was unmarried...I have different responsibilities now. Being married is to be obedient to your husband...it is about being obedient to your in-laws. When I was at my parents' house, I could play with other girls and walk outside in the fields...I cannot do that anymore. I need to sit inside because it is shameful for a married woman to go outside on her own... I clean the house, didi...and at times I also work in the fields with my husband when he has a lot to do...and then I cook...”
(Sita, a 15 year old adolescent bride)

The passage above illustrates how a young married woman perceives her married life. Sita talks about a transition that takes place from when one is unmarried to when one gets married. This transition is marked by two changes: not being able to move freely outside the house, and acquiring different responsibilities. When she was unmarried, Sita could play with other girls and walk outside in the fields. During our field-visits, we observed that there was a clear difference between unmarried and married women. Young female children, who had not yet reached puberty, could move freely from one house to another, and play in the local fields with other boys and girls. This meant that parents did not differentiate between whether a girl could only have other female playmates but allowed the girls to play with children of both sexes. However, older unmarried girls and married girls could not move freely. They were confined to their homes and engaged in household activities. This is discussed in greater detail in the previous chapter. Unmarried adolescents, who were not at school, took care of their younger siblings or performed various household activities within the house. We were told that this was because they were brides-in-making. By this the villagers meant that the girl was learning all the important household tasks so that she would not find the transition from being unmarried to being married difficult.

Another visible difference between unmarried and married girls was that the former did not wear a veil on their head and wore different types of clothes than married women. Married girls wore a *Saree*¹² whilst unmarried girls wore a *salwar kameez*¹³ or skirts and blouses. Married women used the end of their sarees as a veil to cover their heads and faces. This system of covering of the head is called *purdah*, which is not only a symbol of one's marital status but is also carried out as a measure of what the participants refer to as protecting *izzat* of their bridal family. *Izzat*, in this context, means honour, and a married woman is considered to be the honour of patrimony.

“Married women in our community cover their heads with the pallu (end of the saree). The pallu is a woman's izzat and the izzat of her husband's family. If a woman who is married does not cover her head, she is beshareem (defamed) and she is ruining the izzat of her family. If anything bad happens to her (talking about possible sexual harassment from community members) because she does not wear the pallu over her head, then it is her own fault”.

(Devi, an adolescent bride)

Veil, therefore, serves several purposes in this society. Alongside being a symbol of being married, it also serves to protect a woman from possible sexual harassment from other community members. This also implies that if a married woman, who does not wear a veil, is considered loose, and if she is sexually harassed by a community member, she will not be taken seriously by community members.

Andrist suggests that teaching the women to wear a veil is not merely teaching them when it is appropriate to cover one's face but it is also a symbolic act that encourages women to internalise norms and situational contexts as to when they should feel shy and whom they should treat with respect (83). Jejeebhoy argues that the *purdah* system is not only about covering one's head but can also be seen as a symbolic act that leads to the subordination of women (11). Andrist also suggests that young unmarried and married women's confinement within the household is symbolic of both protecting and controlling women's sexuality (83).

¹² Saree is a traditional Indian dress for married women.

¹³ Salwar Kameez is a long tunic with trousers that is usually worn by Northern Indian women and in this area only by young, unmarried girls.

Andrist further suggests that purdah system is more common among women from rural areas and women with no or very little education. The use of purdah and traditional clothing faint the higher the education a woman has and the further away she lives from rural communities. Furthermore, purdah system is also a product of age, where older women are more likely to cover their heads irrespective of whether they live in rural or urban areas (83). These findings are in correlation with our observations and interactions with village women, who increasingly wear a veil if they are older, in front of all male members of their own family and community, and refrain from wearing a veil if they are only amongst women.

The transition from being unmarried to married is also marked by a perceived shift in responsibilities. These responsibilities vary from carrying out household chores, such as cooking, cleaning and taking care of the elderly, to working in the fields alongside the husband, to having sex with the husband. Within the domain of responsibilities, being obedient to one's husband and his family, and having a baby are perceived to be the most important responsibilities of a married woman. For instance, Madhoo says:

“Married life is all about responsibilities...about taking care of your husband's needs and his family's needs. It is about obeying what they tell you and to do what they want you to do. The biggest responsibility is to give the family a new child...being fertile is very important in our culture. Having a baby boy is even more important. I was very unlucky...not only that I had a girl but she also died...now I need to try and have another baby soon...or it will be bad for me...”

(Madhoo, a 15 year old adolescent bride)

The notions of being obedient to one's husband and his family reinforce a hierarchical family structure, where women's roles are defined by how obedient they are and whether they do what they are told in a given setting. Henderson suggests that this attribute is vital in an Indian woman's aspiration of being the 'perfect wife' (1). She writes that an ideal Indian wife is someone who realises the role of *Satimata*¹⁴ perfectly. A satimata is someone who is truly virtuous and someone who personifies goodness and truthfulness. Virtue, here, can be understood as being faithful to one's husband. Being a perfect wife is seen as a woman's *dharma*¹⁵. According to the Hindu scripture, *Manu Smriti*, which is text dictating the laws of

¹⁴ Satimata: Protective Goddess in Hindu Mythology

¹⁵ Dharma: Duty

how an individual should live; it is a woman's duty to be obedient and faithful to her parents when she is unmarried and to her husband when she is married. It is also her duty to treat her husband's friends with affection and to not engage in sexual activities with other men but her husband either before or after marriage. This distinction is not made for men, however (84). She is also supposed to control her passions (physical), to be an expert in household affairs, and even avoid dressing up if her husband is away from home. Furthermore, a woman needs to be fertile and cherish children.

We asked the participants what roles a woman plays in her married life. The most common responses were that a woman should be pious, that she should work hard, be supportive to her husband, obey his orders and please him and obey the elders of his family. When we asked what their husbands' needs were and what they meant by pleasing their husbands, the young married women replied:

"You know...to do what he wants me to do. If he wants to have a child, then I should respect that. Also, to obey him when he wants to bed me...to support him in his decisions...things like that are a woman's dharma. You should be faithful to your husband and not ask too many questions". (Devi)

"You know, didi, the husband in our culture is our God. One must obey one's God...if he wants you to do something, you should do it. I do not always want to do what he wants...but what can I do. It is my duty to do what he wants...Also you cannot do anything without telling your husband...or you will be in trouble...I mean of course you should also ask his parents but everything should go through your husband and not you...he makes important decisions" (Nafisa)

These responses illustrate the position a man enjoys in this society. Women play subordinate roles within a marriage, where men make important decisions. These decisions may vary from requesting permission to go outside of the house to making decisions as to when to have sex. This again brings us back to the issue of women's autonomy, which many researchers argue is threatened by such cultural structures (2-6;11;35;36). Nafisa tells us that the husband is considered as a married woman's God and Devi talks about how supporting her husband's decision is her dharma. Dharma, here, refers to a woman's marital duties. At the marriage ceremony, both men and women pledge that they will fulfil their dharma throughout their married lives. The participants tell us that a woman gains more respect within the family if she is obedient and if she does not open her mouth too much. Not

opening of mouth entails agreeing to what she is told. Radha, however, tells us that the terms of dharma are dangerous:

“How can I not open my mouth? I mean...I am treated like a curse to this family because I do not have a child as yet. My sisters-in-law say a lot of bad things about me. My mother-in-law does not like me because I do not have a child. She does not think that I am worthy. How can I just not open my mouth? And then...my husband wants to have it three times a week...at times I do not want it...and he beats me up...how can I not open my mouth?”

(Radha)

When asked how she opens her mouth, Radha tells us that by talking to us, she is opening her mouth when she tells her friends about being the black sheep of the family as she does not have a child as yet. We ask her about the consequences of opening her mouth, and she tells that she will just get beaten up by her husband if someone finds out that she was badmouthing her family. Crying, she tells us that she does not think it is in her husband's dharma to hit her. When we ask her about the instances where her husband hits her, she tells us that these instances are most often related to having sex. This is discussed in the next section.

In summarising what it entails to be married, young women tell us that it is to be obedient- to their husbands and to his family members. Being married entails being responsible, being doing what you are told, and executing one's dharma of having children. This view of one's married is reminiscent of possessing very little control over one's body. This is discussed in the chapters below.

5.4 #Objective III: Explore the context within which sexual and reproductive health decisions are made

This section presents the context within which sexual and reproductive health decisions are made by young married women who participated in this study. I have divided this section into two parts: knowledge and importance of being sexually active and the factors that influence these sexual decisions. Thus, the first chapters will deal with what women think of being sexually active and what are the most important reasons for being sexually active. The next chapters will consider issues such as influences from in-laws and migration and how these play a role in determining when and how a young married woman seeks healthcare and how.

5.4.1 *“I did not know what sex was until I was there...in front of my husband on our wedding night...”*- Dimensions of being sexually active

I. Being Sexually Active:

“I did not know what sex was until I was there...in front of my husband on our wedding night. My mother told me that I needed to do whatever my husband or his family wanted me to do...I did not know what was happening until he was there...I cried and thought that he was mad at me, that he was going to hit me (laughs). My husband has lived in the city so he knows a lot about it...” (Nafisa)

The previous chapters discussed the reasons for the existence of adolescent marriage, and what being married means for the participants of this study. We also explored the notion of being sexually active and its importance for young women. There are several reasons for this choice. Our interactions on what it meant to be sexually active would not only help build a platform for the understanding of various types of sexual and reproductive health services that are accessed by and available to young married women but also tell us something about how they make such decisions, whether they engaged in pre-marital sex, what they know about sex, how they view being sexually active, and what is important for them.

In the passage above, Nafisa tells us that she did not know what sex was until her husband was actually having sex with her on their wedding night. This notion was also shared by Saira and Madhoo. Madhoo told us that her mother had told her to do what her husband had

wanted to do and to not refuse. When I asked her how she initially understood this request by her mother, she told us the following:

“Well I did not know that my mother was talking about this (sex), actually. I thought she was talking about household chores, you know (laughs). I did not really relate her telling me what I should do to this. There is a tradition that the mother tells her girls to do what the husband and the husband’s family say...”
(Madhoo)

Krishna, Sita, Pooja and Devi told us that they knew what sex was before marriage, and that they were not completely shocked when their husbands wanted to *sleep next to* them. They also told us that it was expected of them to sleep next to their husbands now that they were married, and they did not feel that it was so difficult. However, their understanding of sex was quite different from what they experienced the first time they had sex. Pooja told us that she thought that the act of sex involved people sleeping next to each other. This meant that a man and a woman would sleep next to each other and not with each other. Sita expressed this as well and said that she thought that she would get *a baby in her stomach* as soon as her husband touched her. Devi told us that as she has older sisters and an aunt who live close by; they had told her about what sex was and how it happened:

“You know it helps to have someone nearby who is older than you. They tell you what to expect and they tell you about the reality of things...I mean she told me that it hurts the first few times and that I should not worry too much...Of course I had never seen a man without clothes before and I did not know what they really meant when they told me that it would hurt but I thought that it would be fine. My sister told me that I should do what my husband wants and that if he wants it, then I should not refuse...” (Devi)

Radha told us that she was afraid that she would get pregnant because she had hugged the neighbour’s boy before getting married. So they had decided not to touch each other until they knew that they would get married. She also said that she had discussed these ‘intimate’ matters with her friends who were in the same situation as her but that she had come to the conclusion that she did not want to ruin her father’s reputation by getting physically involved with someone, especially as she was going to be married off to someone else. She said that her husband thought it was really important that she bled the first time they had sex. This was painful for her and she did not really understand why she would need to bleed.

“He told me that I was a good girl because I had bled and that it should bleed when a girl has sex for the first time. I was just scared why it bled as I did not know what it meant back then. He told me that I bled because I was a virgin...and I guess now I am happy that I did not do anything with the neighbour’s boy because my husband would not have liked that...” (Radha)

These passages illustrate how participants varied in their pre-understanding of sex. Where some participants told us that they did not know about what it was like to have sex before they got married, others think said that they thought that a woman could get pregnant either by sleeping next to a man or by being touched and hugged by a man. These passages also point out that older female siblings and husbands can play an important role in preparing younger siblings for prospective sexual lives. However, what was interesting was that not all participants said that their older female siblings had told them anything about how sexual relationships are formed and what one should expect. In Radha’s case, her pre-understanding had been shaped by having led a platonic relationship with the neighbour’s boy. Radha’s statement on the importance of bleeding reiterates the cultural importance in being a virgin until marriage, and reinforces cultural norms regarding pre-marital sex, as discussed in the previous chapters.

Embedded within these statements is also an indication that young women’s husbands know more about sex than they do. As discussed in the methods section, Sita agreed to participate in this study only if we interviewed her husband first. Sita’s husband, Mahesh¹⁶, is a migrant worker and lives in Delhi most of the time. He comes home to Shivgarh once every month and tells us that he has had pre-marital sex, and that it is quite common among his friends to have done that *it before marriage*. When we asked him where he got to know about sex, he told us the following:

“Well from my friends...especially when I moved to Delhi. Everyone there knows what it is, what one does and how one does it (whispers). Men talk about it amongst themselves...and then you can watch films. Cinemas play films for men only from time to time...especially in the cities. I moved to the city when I was younger and there are cinemas you can go that do not really directly say that a woman should see those films but women generally do not go and see those films. So, that is how I learned...and that is how I, you know...I did it”

(Mahesh, Sita’s husband, is 18 years old and a migrant worker)

¹⁶ The name has been changed.

When asked whether it was common for men living in the village to also have learned about sex by watching films, Mahesh told us that most young men could go to the city, especially Lucknow, which was not very far away from Shivgarh and that in Lucknow, there were some cinemas that showed such films. He also told us that some people who lived and worked in the cities and only came home once a month or less also had sex with women who were not their wives:

“Madam, there are a lot of people who have sex with other women. When the wives live in villages because they have to take care of the families, and men work in the city, it is very common that a man would have sex with other women. These women are not always good women; they work in the sex business. I do not want that to happen with me so I come home often enough and I want my wife to move to the city with me...” (Mahesh)

Taking into consideration what the participants told us about their being restrictions on their mobility, these statements can indicate how men and women receive differential treatment growing up, where men can travel and engage in various activities more freely than women. Mahesh’s statement also illustrates that it is common for migratory men to have extramarital affairs with sex workers. We also asked Mahesh if he had told his parents about him having sex and he said that telling parents about such things was out of question, and that it was against their culture to engage in pre-marital sex. He told us that young people do not openly discuss their sexuality in his community and that you have to be good friends to know who is doing what. We asked him whether he would have objected to his wife had had pre-marital sex. He said that it was a sign of bad character, especially for women.

“Men can do that kind of a thing because it does not make a difference. Women should not do that with anyone but their husband because if they do it with anyone else, then they have bad character. A wife should be someone who is shudh (pure) and she should not do anything like this with anyone but her husband.” (Mahesh)

This statement illustrates how there exist two different standards of appropriate sexual behaviour in this community. Alternatively, this statement indicates the importance given to women being virgin or pure, something that is also expressed by Radha’s husband when she bleeds on her wedding night.

II. So why should one be sexually active?

Alongside asking women about what it entails to be sexually active, we also asked them why one should be sexually active. This was done in order to understand what was important for them within their sexual lives. The analysed data material showed that being sexually active meant two things for the participants – it dictated their feeling of being worthy and their ability to produce a baby. These two components of being sexually active were gradually learned during the initial phases of their marriages. In the first section, we learned that women did not know much about sex and that they thought that they could conceive simply by being touched by their husbands. We now asked them the importance of being touched by their husbands:

“If your husband touches you, I guess that means that he is happy with you. I mean...he is not going to leave you. A lot of women in our community get thrown out by their men simply because men do not like their wives.”

(Krishna)

“If your husband keeps you, this means that he will provide for you. We women do not earn money, what will happen to me if he throws me out? So it is good that I accept what he does to me...it is also my dharma to please my husband...so when he touches me, I think he is right to do so.”

(Saira)

The two passages above show that fear of being thrown out of the house and not being provided for as a result of being thrown out dictate women's understanding of why it is important to be 'touched' by their husbands. According to the Indian (Hindu) Adoptions and Maintenance Act of 1956 (58), the husband is legally obliged to provide for his wife in all circumstances and in case of divorce, he has to provide for his divorced wife up until one to three years after the divorce. It seems as if being sexually active translates into continued financial support from husbands. George describes this phenomenon as being the main reason for why young married women continue living in sexual relationships despite the existence of violence and unwillingness to have sex (38). Bott et al. label this strategy as a survival mechanism used by women in cultures where they do not possess control over their bodies (24).

Radha tells us that she goes through with sex because she wants to get pregnant so that she does not need to have sex again. Having a baby is seen as an important reason for why a woman should be sexually active. This notion is shared by all participants, who say that having a baby is an ultimate goal of a married woman. Nafisa, who has just had her first

child, tells me that having a baby made her feel worthy. Radha tells us that as she has not got pregnant as yet; her in-laws question her worth and think that she needs to prove her worth. The participants' notion of becoming a mother is also related to their cultural notion of being an ideal wife. According to the Hindu scripture of *Manu Smriti*, an ideal wife is someone who is fertile and has children. Although girls and infertile women do not enjoy high social status within a traditional community such as Shivgarh, motherhood is highly valued and is the ideal role for any woman within Indian society (67).

Being sexually active, therefore, is understood in two different ways by this group of women – it becomes a survival mechanism in cases where women fear that they will be thrown out of the family if they are not sexually active; and it is closely linked to one's ability to produce children or fertility. As outlined above, fertility and motherhood are hailed in the Indian society. In this study, the concept of fertility is important in participants' understanding of their self-worth within their families. The participants reason that their ability to become pregnant dictates how they are treated by their in-laws and community members. Radha expresses the notion of being labelled family's black sheep simply because she has not been able to become pregnant as of yet. Madhoo says that her in-laws think that she has shown her worth of being a woman despite the fact that she lost her first child. She says that she will soon try to become a mother again so that she can enjoy a higher status within her family. This understanding of fertility is not unique to the peoples of this study only and has been documented widely throughout history. Skirbekk notes that having more babies was traditionally seen as having wealth and higher status (85). Chodorow suggests that the ability to have babies is what distinguishes masculine and feminine personalities and sex roles. These roles are central to women's sense of self and in the development of self-worth (86).

Implications of these findings for the participants:

In the passages above, I described the varying types of pre-understandings of sex amongst participants and what being sexually active means to the participants. Pre-understandings of sex included not knowing much about sex, misconceptions regarding how one gets pregnant and the importance given to bleeding as a result of hymen being torn during vaginal intercourse. Furthermore, I also showed how one of the husbands talks about where he learned about sex and how men that he knows learn about sex and sexual activities. Being

sexually active was understood as having two functions – reproduction, and in ensuring continued financial support from husbands.

From a public health perspective, not knowing about sex or having misconceptions regarding pregnancy and sex may have direct or indirect implications for an individual. MacIntyre suggests that due to the social isolation of young girls before and within marriage and lack of access to education, these women are often the least well-informed group of young people about sexual health issues (6). He illustrates that in countries where early marriage is culturally acceptable, young women tend to have significantly less knowledge about what sex is and how babies are conceived post-coital sex. In a study on newly married young women from urban India, George suggests that many young married women recall their first sexual experience within marriage as being a time of confusion and shame (38). This is because they feel shyness when they are faced by sex without any prior knowledge of what it is. George's study shows that some of the married women see sex as a pragmatic arrangement that is natural within married life, a finding that is very relevant for the participants of this study. It also seems as if this pragmatic solution is valued by participants' older sisters and mothers who advice young girls to do what their husbands want, which in most cases means agreeing to have sex with them.

George describes that brides experience a sense of sexual shyness that springs from lack of sexual knowledge, lack of details about sexual intercourse and how it plays out in reality (38). She suggests that although Indian society discriminates against pre-marital sex, sex after marriage is encouraged and usually starts from the wedding night taking place in the in-laws' house, where family members easily find out whether the couple have had sexual intercourse. The sense of shyness is strengthened by the bride not knowing anyone in the new family. Brides also express a sense of fear as they do not know what is about to happen. In this study, Nafisa tells us that she felt scared that her husband was mad at her and would beat her. This fear and shyness may have adverse implications for the health of young women not only because they do not possess control over their own sexuality but also because they might have to put up with violence within the marriage. All young women who participated in this study express their fear of their husbands beating them if they refuse to have sex. This is best expressed by Radha and Madhoo:

“How should I tell you? He wants it three times a week. When I refuse, he beats me and forces me. I guess I do not really have a choice. It is painful and it hurts. I just want to have a child soon so that I do not have to go through with it again...” (Radha)

“Didi, he does not tie me up or anything but he hits me if I do not sleep (next) to him. So now I just do that so that in the fear of not getting beaten up. It is best that way. I cannot refuse my husband this; I guess...This friend of mine was telling me that her husband ties her up if she does not want to do it with him so I guess I am better off that my husband is nicer...” (Madhoo)

This shows that these girls see physical violence as being part of being married, and part of being sexually active. MacIntyre suggests that young married girls are likely to say that it is acceptable for a man to beat his wife (6). George’s participants call this marital violence as being parts of their lives, parts of what it is to be a married woman (38). They say that if a married woman does not have sex with her husband; she will either get beaten up or left as she was brought to the new family precisely because of this. This analysis illustrates two different things – that women do not possess control over their bodies and that their bodies are used as vessels for having sex. The findings of this study are in line with George’s findings that see being sexually active as being a function of ensuring economic stability as women themselves do not have paid jobs and do not think that they will be able to fund themselves once they get thrown out.

Studies on young married women’s knowledge regarding sex from cultures where early marriage is acceptable have shown that young women who do not know about sex are at risk of acquiring sexually transmitted infections, HIV and AIDS (6). Misconceptions as to how babies are conceived can be seen as an indicator of what women know about contraceptives and the transmission of sexual infections as well as pregnancy. Sundby points out that right to the necessary knowledge and means to make informed choices around one’s own sexuality is one’s human right (21). The findings of this study indicate that no or very little pre-understanding of sex suggest that the participants of this study have not received any formal (e.g. school) or informal (e.g. through parents, peers and siblings) sexual education about sexual intercourse and its consequences. The issue of informed choices will be dealt with in the next chapters on how sexual decisions are made, what types of contraceptives women use and why and which sexual health services are available to them through the National Rural Health Mission.

An issue that has not been discussed so far is the way being sexually active is only seen as a function of reproduction and not sexual pleasure. None of the participant discusses this particular aspect of being sexually active that the World Health Organisation's definition of reproductive health entails (87):

Health is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, reproductive health addresses the reproductive processes, functions and systems at all stages of life. Reproductive health, therefore, implies that people are able to have a responsible, satisfying and safe sex and that they have the capability to reproduce and the freedom to decide if, when and how often to do so.

Implicit in this are the rights of men and women to be informed of and to have access to safe, effective, affordable and acceptable methods of fertility regulation of their choice, and the right to access to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant.

Although very mechanic, this definition suggests that sex should be satisfying and safe, that it should be an individual's own free choice to have sex whenever that individual finds it appropriate to do so. Young married women's statements above do not illustrate this freedom of choice; nor do they suggest that women experience this sexual experience as being satisfying. This freedom of choice is also illustrated in the Beijing Platform for Action (88), that suggests:

"The human rights of women include their right to have control over, and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence". – Paragraph 96

From what the participants describe, they do not possess these choices despite India being a signatory to the Beijing Platform for Action. The freedom of choosing when to have sex, however, is exercised freely by their spouses, where it seems as if the spouses do not take into consideration whether the women want to have sex or not. The function of sex, according to the above statements, is to procreate and to ensure that a woman does not get thrown out of her house. Through Radha, we find out that she gets beaten if she refuses to have sex. This is also the case for Madhoo. According to the National Family Health Survey-

III data, approximately 44.3% of women living in rural Uttar Pradesh have experienced spousal violence (14). Spousal violence is defined as being beaten up by husband because of denying sex or denying his will. The question that now arises is whether this type of sex is acceptable or whether it is a violation of a woman's human rights. The type of sexual activity described by the participants in the passages above is not sex that occurs on women's premises. It is described as a form of submission, a better option than ending up on the street or feeling worthless as a result of refusing to have babies. This finding, again, reiterates the importance of women's autonomy and how lack of control over one's own body may lead to the violation of human rights.

5.4.2 *“They talk behind my back, they do not think I can have a baby...”* - What is the context of sexual health decisions?

I. The Influence of in-laws in decision-making:

“If I could wait with having a baby, I am sure I would have waited. But you know how it is, didi, in our community, the mother-in-laws talk behind your back. They are always ready to find any faults in you and to throw you out so that they can get someone else in who can produce many babies...oh well, I guess having a baby has shut her up for a while...”

(Nafisa)

“People think that I am the black sheep of the family...they talk behind my back and think that I cannot hear them. I know what they all say. I do not have a baby yet. Hopefully God will hear my prayers and fill my stomach so that I do not have to hear all of their accusations. It is sickening...I work here all day... I work with my husband in the fields; I make the food, clean up and my mother-in-law and sisters-in-law tell me that I have a bad character and that I refuse my husband what he deserves...of course I do not...I do not know what it is but I am not able to have a baby...”

(Radha)

“My friends tell me that I should wait with having babies...and I really want to but I do not think I can. It is expected of me to get pregnant within the first two – three years of marriage...or I will get thrown out and someone else will take my place. Women are disposables; you know...if one does not work, the other one takes your place...”

(Faiza)

The passages above illustrate the type of influence in-laws and community members have on women’s decision-making related to their sexual and reproductive health. Where participants tell us that they feel obliged to have sex with their husbands because it will keep them financially secure and give them an opportunity to have children; their decision-making powers are highly influenced by what their spouses’ family members and community members think of their sexuality. We are told that being fertile is extremely important in this community, and that the upper limit to prove one’s worth, that is have a baby, is two to three years after marriage. After this time-period, a woman is divorced or simply left and the man re-marries. This tells us something about the place a woman enjoys in this society, something which Faiza describes as being “disposable”. Radha tells us that people use adjectives such as black sheep when they refer to her inability to have a baby and accuse her of holding back on sex, something that her husband deserves to get from her. These attitudes reinforce a view of women being vessels that carry a baby and a man’s birth right of having sex with his wife.

What is also interesting is that these practices are upheld by women, and older women or older sisters-in-law become agents of discrimination against younger brides.

Madhoo tells us that she cannot move around freely within her own house or the village without telling her mother-in-law about her whereabouts let alone make decisions as to whether and when she should have sex with her husband and when she should have her next baby:

“Didi, older women do not understand that they themselves were young once and that what they accuse us of, they were accused of once. I cannot even go from this house to the next house without telling my sasu ma (mother-in-law), let alone make babies without her interfering in my life. When a woman gets married, the sasu ma tells the newly wed to go to the husband’s room. This is an open permission to let the husband do it to the wife...they hear everything, they see everything...it is like they have three ears and four eyes. Sasu ma knows everything...”
(Madhoo)

The mother-in-law plays an important role in all aspects of the newly wed’s life. She decides whether the young married girl should have sex with her husband, go out to work or when she should start having babies. We asked whether health workers experience the interference of family members when they are working in the field. Rani tells us that one cannot start talking to the pregnant women without going through what one is going to say with the sasu ma first:

“Oh, the sasu ma is the most important person in the family. You cannot step in the house without the sasu being suspicious of you and thinking that you are going to pollute the mind of the young woman by telling her things that she should not know...So the first thing is to tell the sasu ma that we are only there to help them and not hurt them. Still, these women sit next to the pregnant women and listen to everything we say...it is not like the women can talk about personal things with us when they are there...but there is not much you can do when our society is like that”.
(Rani, 28 year old ASHA who has worked in the field for two years and five months)

During our observations as well as before interviewing young women, this was something that we came across very often. The involvement of mother-in-law and lack of privacy was often an issue until the mother-in-law was satisfied that we were not going to pollute her daughter-in-law with some ‘modern’ information. As my fieldwork assistants knew villagers well, the mother-in-laws were less suspicious of us. Returning to the point Rani makes about how women may not be able to share personal things with them, illustrates two things – young women do not possess much control over the choices they make, and that mother-in-

laws play a significant role in the decisions they do make. Another health worker, Reshami, who has worked as an ASHA for the past year, told us that if a mother-in-laws and husbands were the ones who decided when, where and how a woman would receive treatment, whether they would attend the ante-natal care programmes or deliver at home, at the local government hospital or seek private treatment.

“The sasu ma and husband are very important people. The health worker needs to talk to one of them before we are even allowed to talk to the woman. Being a woman, the health worker does not really feel comfortable in talking with the husband about women’s things (women’s health), so we talk to the mother-in-law instead. I can say what I want but if the mother-in-law does not want something to happen, she will have the last say. So, even if I tell her that it is good for the bahu (daughter-in-law) to deliver at the hospital, if she does not want it, it won’t happen.”

(Reshami)

“My family (mother-in-law and husband) did not want me to deliver at the local hospital because women are not treated well there...they know this private doctor whom they trust. So I delivered my baby there...I know a lot of women who deliver at home so I guess I was lucky that I was not one of them because I had complications...the doctor was helpful but sadly, we had to pay a lot of money to deliver.”

(Nafisa)

Upon finding out who made the most important decisions in the family, we asked the women and health workers why they thought mother-in-laws were so important. They said that it was because of her age that a mother-in-law plays an important role in all the decisions that are made. They also said that mother-in-laws always listen to her son and cannot make a decision alone. Reshami expresses that she cannot talk to the husband about sexual health. This is common to all health workers who suggest that it is very difficult to talk to men about sex and pregnancy. I will come back to this discussion in the section on family planning in greater detail. Thus, from a health worker perspective, mother-in-laws become an entry point in their intervention on women’s health as their trust needs to be won in order to gain access to their client – the married woman.

II. Migration and its influence on sexual decision-making

Migration is another factor that plays a role in decisions related to sexual health. We learned earlier that Sita’s husband, Mahesh, is a migrant worker. Sita, although she wants to wait with getting pregnant, tells us that her husband wants her to get pregnant so that she can move to Delhi with him. Her mother-in-law, however, does not want her to get pregnant just

yet as her help is highly needed in household chores in the village and she needs to take care of the family. Sita tells us that:

“My sasu wants me to wait with pregnancy. She tells us not to have sex. She tells us that we should not sleep in the same bed because then I will get pregnant and this will make it easier for my husband to take me away to Delhi”.
(Sita)

Sita also tells us that she cannot refuse her husband sex because he wants it at times. So they have to wait until the mother-in-law is out of the house. We ask her how they manage to not get pregnant and she says that he has told her what works and that he pulls away whenever he ejaculates. She says that it works so far but that she is afraid that her mother-in-law will find out and that can have consequences for her seeing her husband. Sita tells us that she wants to move to Delhi but that she wishes that she could move without having to get pregnant first. She pleads by saying that every woman should be where her husband is and that she is worried that no one is there to take care of her husband in Delhi.

This illustrates that both familial influences and migration may affect women's sexual health decision-making strategies. These findings, again, indicate that it is not the woman herself that makes decisions related to sexual health but that elder members of the family, especially the mother-in-law and the husband make important decisions related to a woman's health.

Implications of others' influence on sexual health decisions:

There are both direct and indirect implications of someone else making decisions related to one's health. First and foremost, other people may not know everything about one's needs. The woman may, therefore, not receive appropriate healthcare due to others deciding what she needs. Secondly, women may end up making decisions that may or may not want as a result of pressure from mother-in-laws and/or husbands. The findings from this study suggest that mother-in-laws play an important role in deciding what is best for the daughter-in-law. These decisions are not only limited to deciding when to have sex or where to deliver but are manifest in all walks of life. In her study on women's autonomy in rural India, Jejeebhoy suggests that women from traditional families within Uttar Pradesh do not enjoy high level of autonomy (11). The word autonomy, here, denotes having control over one's body and mobility. She suggests that the level of autonomy exercised by a woman within rural settings in India varies from North to South, and is defined by patriarchal or matriarchal organisation of communities. For instance, a woman in Tamil Nadu, which is a province in South India,

may go to the healthcare centre on her own or with other women. This is not the case for the participants of this study. Jejeebhoy outlines that such differences exist simply because women are given more importance within a Tamil household than within a household in Uttar Pradesh. This means that the 'value' given to women decides whether she is deemed capable of making decisions related to her own health. According to the human rights framework, lack of self-control on one's sexuality is a direct violation of a human's right. The participants of this study express that their mother-in-laws interfere on all levels of decision-making processes, and that they cannot even move from one place to another without their permission. The presence of a mother-in-law at every meeting with the health worker poses a threat not only to the confidentiality between the health worker and 'patient' but also indicates that a woman may not ask the health worker about issues she does not feel she can discuss openly. This may indicate that in cases of women may not contact the health workers directly if they experience changes in their health, and may have to go through their elders who may or may not see the necessity in taking them to the healthcare centre.

Thus, the contexts within which young women make sexual health decisions are controlled by mother-in-laws and/or husbands. Furthermore, women may not initiate sex because they feel pleasure in doing so but because of a perceived need to 'obey' their spouse, in getting continued financial support from them, and to procreate.

5.5 #Objective 4: Explore the nature of sexual and reproductive health services available to, and accessed by young married women

In this section, I will outline how young married women and their families seek sexual and reproductive health services, and what types of services are provided to them by community health workers. I divide the types of sexual and reproductive health services in two – family planning services and antenatal care. Due to the focus on sexual health in this study, I will not discuss postnatal care in this section. The section on family planning includes an analysis of the most commonly used family planning methods by the participants of this study, and otherwise in this community. I present both young women's as well as health workers' perspectives on what is 'best' to use and why. The section on antenatal care will discuss how pregnancy is detected, what types of pregnancy-related healthcare is available to the participants, and how they utilise these services.

5.5.1 “*Parivar Nayojan...what do the young ones need that for?*”- Perceptions on Family Planning Services and their importance.

I. Health Worker Perspectives on Family Planning Services:

“Parivar Nayojan (Family Planning) for young women? No no no, didi...that is not the point of these services. Young women do not need to know about family planning. I mean...they have all their lives in front of themselves. They should give birth to a few children first before I can talk to them about using this or that...” (Mala, a 30 year old ASHA, who has worked as a health worker for the past two years)

“Arre (oh)...parivar nayojan is not something young married women who do not have children should worry themselves with...it is for women who have got at least two or three children. Besides, it is not like these girls need a reason for why they should use medicines (contraceptives)...It is important for the young ones to first become mothers before they, you know...start thinking about these kinds of things...” (Anju, a 35 year old ASHA, who has also worked as a health worker for the past two years)

Mala and Anju are two of the eight health workers who participated in this study. Like the other health workers, Mala and Anju told us that their jobs entailed visiting married (mostly pregnant) women at their homes and in encouraging these women to deliver at the hospital. I will come back to the nature of antenatal care visits and hospital delivery in the next chapter. They told us that they had also been trained on giving family planning advice to women, and

that some community health workers even had access to certain contraceptives through the auxiliary nurse-midwife.

The observations and interviews illustrated that family planning advice, albeit an important part of a community health worker's job, was restricted to certain subsets of the female population, and not everyone. In the passages above, Mala and Anju describe a bias that is shared by all health workers. The health workers do not see the need for why family planning services should be given to someone who is not a mother. The general notion is that family planning services should kick in as soon as a woman has had more than two children. When asked how they intervene if a woman in their community has already borne two children, the health workers say:

"At the training, we are told to tell the women that now that they have two children, it is enough. This is especially if they have a boy and a girl. I can understand why people want to try for more kids if they only have two girls...but the health people want us to tell the women that it is enough now...that they should get sterilised after having two children. So we tell them to get the operation...we tell them that it is not good to have many children because education is expensive...if you have many children, how are you going to fund their schooling or buy them new clothes? We tell them all this...and some of them listen. If they do not, then at times we make them understand by forcing them to understand..." (Malini)

"Yes, yes...you know it is really pathetic that older women have children at the same time as their daughter-in-laws. They should really learn...I feel ashamed when I have to talk to a grandma and tell her that madam, it is enough...you should get sterilised. In these cases, I tell her how shameful it is for the community that she is doing what she is doing at her age...she should assume other activities...her time has gone." (Mala)

In their intervention on controlling pregnancies, the health workers tell the women that a small family is a happy family, and that it would be very difficult to afford anything more than two children. Family planning interventions in this community are not only based on the number of children one already has but are also based on the age of the recipient. Mala expresses her feeling ashamed when she has to talk to an older woman who is pregnant as she does not feel that it is appropriate for older women to have babies. This feeling of shame reiterates the importance given to early childbirth within marriage.

These findings illustrate a number of things. First and foremost, family planning services are narrowed down to population control alone, and do not seem to include advice on sexually

transmitted infections, and how to plan for a safe sex life that should be enjoyable and satisfying. We learned earlier that sexual intercourse is a function of reproduction rather than reproduction being an integral part of a satisfying sexual life. We also learned that having a baby is very important for men and women in this society, and is related to a woman's feeling of self-worth. Our interactions with health workers confirm these views, as they do not see the need to give family planning advice to someone who does not have a child as yet. Thus, their biased 'supply' of family planning advice is influenced by cultural norms regarding sexuality and childbirth, and determines who gets access to which services. Although the Reproductive and Child Health National Program Implementation Plan-II outlines a need for strengthening family planning services for young married women in urban and rural India (89), it does not consider the importance, and influence of culture in the quality of services provided. Nor does it assess the reasons why health workers place a stronger emphasis on cultural norms rather than providing a universal family planning package as envisaged by the government. What this study does illustrate, however, is the fact that health workers are part of the cultural system that places an enormous emphasis on the mechanics of having sex, and that health workers are part of 'vicious cycle' that instead of controlling population leads to increased number of pregnancies and births. This phenomenon is described by Skirbekk, who suggests that fertility tends to be higher in poorer people who have no or little access to family planning services (85). Our situational analysis, so far, has pointed out that young married women have an unmet need for sexual education. This can be extended to having an unmet need for family planning services as their access is restricted by cultural norms that suggest that they should become mothers before they can learn what planning for family should entail.

Indian government was one of the first in the world to formulate a national family planning programme, which was developed in 1952 (90). Family planning programmes in India have traditionally followed a population control strategy, where the federal government has set standards for the regional governments and health systems to decrease population by promoting small family and promote population control (90). From mass sterilisations to banning sex-selective techniques, India has tried to reach millions of individuals who have an unmet need for family planning services. However, the Indian government has always been very interested in setting targets, in giving incentives to health workers to fulfil their assigned quotas in meeting with the targets set within population control policies (90).

Cultural notions of sex and fertility, women's autonomy and power to decide over their own bodies with respect to sexuality and an evaluation of reaching the 'right' target groups have not been considered in these incentive-based programmes. When we ask the health workers whether villagers use any types of contraceptives, we were told that although some women use condoms and others have tried using contraceptive pills, abortion and intrauterine devices as a measure for planning for family; the most common way to plan for family is irreversible tubal sterilisation.

In exploring the notion of why irreversible tubal sterilisation, we are told by the health workers that it is the safest option in not getting pregnant. A health worker, Anuradha, tells us that it is completely impossible to use any other methods because they are either dangerous for the woman's health or because they are not effective. When we ask her why they are dangerous, she says:

"One of the women in my community had heard about copper-t's (intrauterine device). So she asked me that she wanted to get one because her husband had agreed on letting her have it...so we went to the local hospital and I helped her with getting there and stuff...but she started bleeding a lot and then she said that it itched there and she had bad discharge...so that did not really help her, you know. If she had listened to me and got sterilised, it would have saved her the pain."
(Anuradha)

Nandini tells us about a woman in her community who wanted to use condoms. She says that this woman had come to her and asked for condoms because her husband had requested them. Because Nandini does not think she can discuss such intimate matters with women's husbands, she decided to take matters in her hand and get her the condoms from the primary healthcare centre. By the time Nandini got this woman the condoms, it had gone a few weeks and the woman had got pregnant again. Nandini tells us that one can attend the sterilisation 'camps' every Friday at the health centre, where women can get sterilised so that they do not get pregnant.

The notion of sterilisation being the best option available was reinforced by all health workers, who told us that using condoms was not a viable option because a woman cannot always convince her husband to use one and that contraceptive pills led to vomiting and made women ill. Mala told us a story about how one of the community women had started bleeding and vomiting after having taken the contraceptive pill and decided that the pill was not a good option for her.

In the group interview, we asked the health workers whether only women got sterilised or whether vasectomy was commonly practiced in their community. The health workers gave several reasons for why it was more troublesome for men to go through such a procedure as they have to work in the fields, and that their jobs are difficult. Nandini said that for a man to be sterilised, it means that he loses his masculinity and that men may feel inferior if they get sterilised simply because they cannot have children. It is better if a woman goes through with such a procedure. Another health worker, Reshami told us that sometimes it is better for a woman to get sterilised because it proves that she is faithful to her husband, that she is not going anywhere. On this notion, Mala told us that a woman had requested sterilisation because she did not want to get pregnant anymore. Mala had refused because this woman's husband was in the military and she did not know if he would agree to his wife having the operation. When we asked why this was the case, Mala said:

“Madam, the thing is that we are not sure about this woman's character. Her husband does not live here. He does not come very often. Why does she need sterilisation? She is being unfaithful...I tell you, she is...She is probably having an affair and does not want to get pregnant...she has a bad character.”
(Mala)

We asked Mala if she had suggested any other contraceptives to this woman if she thought that she was sexually active. Mala said that she had told her to remain faithful to her husband and to stop fooling around with other men.

“I told her to abstain from sex with strangers. That is just not right. It is not right being so bad.”
(Mala)

This illustrates and reiterates how this woman's need for contraception is not met because of reinforcement of high morale from health workers' side. This was also the case where an unmarried girl had pre-marital sex and got pregnant as a result of her sexual relations. Instead of providing the girl with sexual health advice, the health worker had told her to refrain from sex. It is precisely such attitudes that result in individuals having an unmet need for contraception.

These findings do not only have implications for women's health but are also interesting due to another reason. The Accredited Social Health Activists or ASHA are community health workers that are considered the backbone of the National Rural Health Mission in India. These health workers are voluntary workers who work on reproductive and child health

incentives, and are paid only when they achieve certain targets. For instance, they receive 600 INR for every woman they help deliver at hospitals, 150 INR for tubal sterilisations and 100 INR for every child they can help vaccinate. We ask health workers what sorts of monthly sterilisation targets they work on, and they tell us that it varies if you are an ASHA or an AWW. The Anganwadi worker or AWW is someone who receives a monthly salary but is also entitled to extra cash if she can get a woman sterilised or if she helps vaccinate a child. When the AWW work on a target of helping one woman get sterilised every six months, the ASHA aspire to help two or three every month. This is interesting as it may help explain why the health workers who only get paid per incentive promote sterilisation as a method to plan for family rather than using less invasive methods such as intrauterine devices or condoms.

During one of the field visits where I followed an AWW, I talked to a woman who had just got pregnant despite of having gone through with the sterilisation procedure. She told us that she was asked to refrain from sex for a few weeks after the operation but that refraining from sex was out of her control as her husband forces her into sex every day. Rama Devi, the local AWW, told me that this woman had five children, and that she could not afford sending any of them to school. This woman had tried to convince her husband to start using condoms but he had refused and beaten her up. Rama Devi tells us:

“Didi, this poor woman’s husband said that she was being bad (unfaithful) and that this is why she wanted her husband to use a condom. He beat her up and she came crying to me...so I took her to the health centre so that she could get sterilised. We did this behind her husband’s back because he would otherwise not allow her such a thing...but you know how men are...they will always blame the woman...” (Rama Devi, a 40 year old AWW who has worked in Shivgarh for the past four years)

This passage illustrates the other side of how family planning is used. Rama Devi tells us about several cases where women want to use contraceptives but men either do not allow this or do not think that they are appropriate. We asked health workers whether they talked with men and told them about the importance of using contraceptives. The general notion was that it was not in their job description to talk to men. This was mostly because the health workers felt that it was difficult talking to men about sexuality. Mala tells us:

“You see we all live in the same village, in the same community. I am not like you, didi...I have to live here all my life. I cannot talk to someone else’s man or son about such things. People will call me besharem (defamed) or beat me up...I cannot take that risk...I cannot ruin my reputation...” (Mala)

This illustrates the complex nature of talking about sex openly in this community, and how health workers feel that they are restricted in their work to talk to men because of the nature of information. In fear of being labelled defamed or get beaten up by community members, the health workers, who are all women, refrain from talking to men. Mala tells us that it is the job of primary school teachers to talk to the men in the community but because a lot of them are also women, this does not happen. In the cases where there are male teachers present, the health workers do not think that they have proper knowledge to convince men in changing their behaviours. When asked how likely it is for a woman to use condoms or contraceptive pills in this community, the health workers say that it all depends on the husband. Malini puts it nicely by saying:

“Arre...if your husband wants you to do something, you will do it right? If he wants to use condoms or other things, he will let you do it. The thing is that men in our community do not want to...perhaps because they do not know about it or they do not care what consequences this has for the women...so this is just the way it is.” (Malini)

This statement brings forth a very important finding that has been discussed throughout this thesis – namely that husband’s involvement plays a crucial role in determining the health of a young married woman. This finding also encapsulates the need to involve men and women both in national sexual and reproductive health policies as well as empowering health workers to promoting healthy behaviours irrespective of cultural practices.

II: Young married women’s perspectives on family planning services:

We asked the young married women who participated in this study if they had received any sexual health advice by the local community health workers. Only three young married women had met their local health workers. These three were also the ones who had had children. Nafisa, Saira and Madhoo’s meeting with the community health workers had related to antenatal care and delivering at the local hospitals.

We asked all of the women if they had already used or wanted to use any family planning methods in the future. All of the women were aware of, at least, one family planning method and five of them knew about two or more. All women knew what tubal sterilisation was, five

of them knew about condoms and contraceptive pills. Three knew about contraceptive injections and one knew about intrauterine devices. When asked if any of the women used any method for family planning, only Sita said that her husband pulled away whenever he was about to ejaculate. Nafisa told us that her husband and she wanted to use condoms but that they did not see it appropriate until they had had a few children. Faiza told us that condoms made a woman infertile for her whole life, and was dangerous to use:

“There is no way I will ever use something like condoms. It does not only make you stick to stomach, it also makes you infertile. I want children, didi...I do not want to do anything like that.”
(Nafisa)

This misconception was shared by all of the participants. Young married women also emphasised on the fact that it was their spouses who decided whether they should have use any family planning methods or not, and that they would only do what was told to them.

Implications of these findings on participants’ health:

The findings above illustrate that tubal sterilisation is the most commonly advised and used method to plan for family in this community. Furthermore, family planning interventions kick in when a woman has had two or more children. Sundby discusses that if young people are turned away from health services because they are too young to receive healthcare services (unmarried women having pre-marital sex or married women who are not pregnant), or because of the attitudes by health staff to particular behaviour, these young people are denied the right to health care on the basis of discrimination (21). She argues that teaching young people sexual abstinence or refusing them access to family planning services make such health services irrelevant for this group of people.

Article 12 of the International Covenant on Economic, Social and Cultural Rights (33) states that:

Health is a fundamental human right indispensable for the exercise of other human rights. Every human being is entitled to the enjoyment of the highest attainable standard of health conducive to living a life of dignity.

On a superficial level, young married women living in Shivgarh have potential access to this ‘highest attainable standard of healthcare’ through the National Rural Health Mission. They

have access to antenatal care, postnatal care and family planning services. However, it is the quality of these services that is questionable, and that violates the rights of these women. Thus, it is not sufficient to possess human rights if one cannot use them, if they are unavailable to one because of cultural practices or moralistic attitudes. It is, for instance, a violation of a young married woman's right to contraception, when becoming pregnant regardless of her own wish is forced upon her both by her in-laws, and indirectly by health workers. It is a violation of her rights, when she is not given adequate information as to which methods are best suited to her. It is a violation of her rights, when, for instance, tubal sterilisation is hailed as the only method for planning for family despite their existing several other less invasive and reversible methods.

In an attempt of controlling population, it is important for a country like India to realise that women and men should be made aware of all methods that are available and that the onset of family planning methods should coincide with the onset of sexual behaviour rather than after having had two or more children. There is also a need to strengthen women's need to know about sexually transmitted infections and how to safeguard themselves from these, something that the current system does not allow.

5.5.2 *“Hospital delivery is good for you...”*- Perspectives on antenatal care services

“Women should not give birth at home. A lot of women die in our community and they die because they give birth at home...” (Anuradha)

“I visit pregnant women three times during her pregnancy and then I arrange for her to go to the hospital and then I stay with her all night”. (Malini)

“I did not give birth at the local hospital because those health people cannot be trusted. I have heard so many stories where women get beaten up or treated badly. There are not enough beds, and people have to sleep on the floor or share beds. There are no health people at night and you are there all alone with the ASHA jee. It is better to go to the private clinic because at least you know what you are getting.” (Nafisa)

“Arre...yes, I know we get money to deliver at the hospital...but what do you do if you have to deliver at night like I had to? I gave birth at home...it was so difficult...the Dai had to pull the baby’s head out and now the baby is dead because at the hospital the health people told me that the baby did not have air...” (Madhoo)

The passages above are accounts of two health workers, Anuradha and Malini, and two young women, Nafisa and Madhoo, who have used antenatal care services. Nafisa tells us that she did not deliver at the local hospital despite the fact that women get 1400 INR for delivering at the government hospital. She did not do so because she does not trust the health workers who work there and because there is no one at the hospital in the night time. She said that it was important for her to live and not die, and that she did not find the ASHA’s help any useful because it was not relevant for her. Madhoo tells us that she did not deliver her baby at the hospital simply because she had to deliver in the evening, when there is no one at the hospital. During our observations, we visited the local primary healthcare centre, what the participants refer to as the “local hospital”, where most deliveries are supposed to take place. At 2.30pm, there is no health worker in the building and the pharmacy looks abandoned with no medications. The ASHA accompanying us tells us that this is a common story of every local hospital in the villages. She tells us that the doctors have private practices after 2pm, where they take money to deliver babies, something the villagers cannot afford. We asked the health workers in the group interview why doctors had private practices after working hours at the local primary healthcare centre, and were told:

“Madam, there is no money anywhere. The doctors do not have money to live if they work at the hospital only...and we do not even get the money we are supposed to get because they tell us that they have not got any money from the government. I do not understand, really...I have not been paid for the past four months...and then we have to arrange for the vehicle when we take the woman to the hospital. That is not easy; it costs money, money that I do not have...money that goes out of my pocket. So I have to borrow money...and when I do that, I cannot give it back because I have not got any refunds from the hospital...so the lenders come knocking on my door and threaten me. The villagers do not get the money that they should get because they get told the same thing...now the thing is that they accuse me of having eaten their money...this is just ridiculous”.

(Nandini)

Nandini brings forth a problem faced by all health workers who participated in this study. The ASHA is supposed to get 600 INR post delivery if she convinces a pregnant woman to deliver at the hospital. However, the health workers tell us that they have not received the money from the past three to four months. The AWW have experienced similar situation in their work, where their monthly payments get postponed by two months at times. We ask health workers if monetary issues affect the quality of service they provide:

“Of course, didi...because you get a bad name in the society...people think you are eating their money. They tell you that you are not worth much. In that way, you cannot do much.”

(Anuradha)

“Yes, well you know that we have targets that we have to meet. We get money per woman we get to the hospital. If we do not have money enough to get these women to the hospital because the hospital is so far away, then how should we manage?”

(Mala)

“I applied to this job thinking that maybe, maybe our jobs will become permanent...and that we would get money for the valuable job that we do for our community...but no, two years have gone and the money we are supposed to receive, we do not get. Tell someone else to work for free, and see how that feels...it does not work”.

(Reshami)

It is evident from these statements that the health workers experience shortage of money as a major hindrance in their work. It does not only threaten their reputation as a health worker but also places them in situation where they have to borrow money to survive in their job situations.

The money situation is important in the delivery of antenatal care services as the nature of interactions between health workers and pregnant women are skewed towards health workers convincing women to deliver at the hospital. The health workers are supposed to give

dietary, hygiene-related and vaccination advice to pregnant women. On average, the health worker spends approximately two-thirds of her time on convincing the woman to deliver at the hospital and one-thirds of her time on telling her what to eat and how to keep clean. The health worker does not usually ask whether the woman is experiencing any major problems with her pregnancy. The only questions asked relate to whether the woman is eating green vegetables and if she is keeping clean. There exist clear power relationships between health workers and pregnant women, as the health worker sits on a chair and the pregnant woman sits on the floor when this interaction takes place. The health worker does most of the talking whilst the young pregnant woman listens and nods her head.

During our interactions with young women, we ask whether they found ASHA's advice useful to them. Nafisa, Madhoo and Saira expressed a notion of indifference in the interaction that takes place between them and the health worker. Saira tells us that if her family do not have the money to buy ghee, it is not possible for her to eat it three times a day or that if she does not have any clean clothes, it is not possible for her to wear them at all times. These statements reflect that young women do not think that the health workers completely understand their life situations.

Implications of these findings:

These findings have implications for women's health in that rural women deliver at home, in unhygienic conditions because there are no skilled health workers present at the local hospital. A plethora of research illustrates that home deliveries lead to higher morbidity and mortality both for the mother and the child (40). Furthermore, it seems as if health workers use more time convincing women to deliver at hospitals simply because they get paid if a woman delivers at the hospital. Thus, the other aspects of their intervention become less important, and the focus remains on money just like in the case of family planning services. Furthermore, the dissemination of information seems to be one-way and does not seem to involve both women and health workers, when the latter give health advice regarding what is good for the woman's health. These findings are indicative of how the target-based health incentives can backfire, and pose a threat to women's health rather than saving them.

6. Epilogue

In this section, I will summarise the main findings of this study, list methodological limitations of the present study and provide certain recommendations based on the obtained results.

Inasmuch as poverty and lack of basic amenities are underlying factors for why parents choose to marry off their girls early, it is the cultural norms and views on pre-marital sex, a sudden transition from childhood to adulthood upon having reached the age of menarche, and fear of promiscuity that become the deciding factors in young women being married off before the legal age of sexual maturation in this study. Social dimensions of poverty are manifest in participants not being in possession of their birth certificates as well as their lack of knowledge regarding their biological age. Although cultural constructs of being old enough are relevant in the question of how age should be defined, it is the universalised concept of biological age that drives national health as well as welfare policies. This lack of knowledge reflects participants' lack of access to education – two aspects that are both products of and factors of one another. When lack of access to education leads to lack of knowledge regarding certain concepts; lack of knowledge can also lead to parents not seeing the need to educate their children.

Being married and sexually active in this population is seen as being an obligation, a vital criterion not for the fulfilment of one's pleasurable desires but a vital survival mechanism in receiving continued financial support from one's spouse as well as in keeping one's social self-worth. One's social self-worth, here, refers to the notion of being worthy in the eyes of mother-in-law and other community and family members. The cultural and religious notions of being an ideal wife, or a Satimata, further hamper the development and autonomy of a woman in making decisions on all levels. Participants describe that they have restrictions on mobility as well as in deciding when to have sex, why to have sex and when to have a child.

A woman's sexuality is closely related to her fertility and ability to conceive. Her fertility is not only controlled by her husband and mother-in-law, who hover over her metaphorical marital-bed but also decide whether she will stay in the family or will be thrown out. Mother-in-laws, sister-in-laws and community members' cultural notions of sustainable reproduction influence and control a woman's fertility.

The final, and perhaps most important finding for this study, is the access to and availability of sexual and reproductive healthcare services. Overtly, women do have access to contraceptives through the National Rural Health Mission, where a community health workers or her line-supervisor, an auxiliary nurse-midwife, is a depository for contraceptives. However, health workers prefer the more invasive, irreversible method to plan for family – namely tubal sterilisation. The main reason behind this is not the irreversibility and security of this method in disabling a woman from becoming pregnant but the fact that it is an incentive, where health workers get paid per woman they help get sterilised. This way of valuing human worth reminds us of women being used as vessels that either contain babies or get emptied as bags full of crisps when there is nothing left to squeeze. Similarly, the notion of why one should deliver at hospital is not understood as being vital for a woman's health but seen through the eyes of a monetary incentive that both pays the woman who delivers and the health worker who brings her to the health station. Women share their concerns of there not being skilled health workers during evening or night hours at the local "hospital" and refrain from getting this golden opportunity of making some extra cash. It is not entirely shocking a finding, however, as the government of India has operated on similar five-year plans and incentives of improving child and maternal healthcare. What this does suggest, nonetheless, is the lack of long-term thinking and lack of health systems strengthening to meet the needs of all pregnant women and healthcare workers. This reflects a real need to finance the health workers better so that they are motivated enough to inform the women of the real benefits of delivering at hospitals or what functions all contraceptives really have instead of assuming that all women should go through with sterilisation as a normative method for planning for family.

6.1 Methodological Limitations – Some reflections

Conducting qualitative research, albeit a learning process, is a very difficult task in not only understanding what the informants say but also in analysing and re-constructing their lived experiences to the readers of such research. In this section, I present the challenges related to conducting such research with respect to this study. I will define the study site and population as being 'alien' to me although the participants' ethnic identity is somewhat similar to mine. This study population is alien in the sense that I am brought up in a western

society under very different circumstances and under very different conditions of what it entails to be sexually active or what it entails to decide over my own body. In fact, I live in a country where women enjoy the liberty to decide over their lives much more than the subjects of this research. Thus, conducting sensitive research regarding someone else's sexuality, understanding their notions of normalcy, is extremely difficult a task. Thus, this study has, in many ways, opened my eyes in the sense that I had presumed that my participants would not be individuals that were ever happy or lived miserable lives. In fact, they surprised me by their 'joie de vivre' in that they coped with their life situations, and had a very 'let us get on with it' attitude. In the planning phases of this study, I had also been told that it would be extremely difficult for me as a foreigner to even get access to sensitive information in that women from rural India do not talk about sex. However, as my participants got to know me, they also opened to me. Being a woman became much more important than any cultural differences that I had previously anticipated.

Nonetheless, it is important to note that cross-cultural research involving different language may add to an additional layer of bias within the interview process. This may even threaten the validity of the study, where the interviewer may interpret the findings differently than they had been anticipated by the subjects. The presence of research assistants may not necessarily be positive in gaining access to the field but also affect the responses given as the participants may not open up in front of people they interact with on an everyday basis. This may threaten the reliability of responses provided.

One of the major limitations of this study was the value placed in pre-determined activities (for observations) and pre-determined questions during interviews. Although I did have the room to ask follow-up questions, the responses were still coloured by the themes that I chose to study. Additionally, the interviews were set in settings that were most natural to the participants – homes in the case of young married women and 'field' or health centre for the health workers. These settings were, at times, over stimulating and filled with distractions. As the older women were always interested in what was being said, we had to discontinue the interviews at times.

Having said this, the most important limitation was perhaps the oversimplification of the complex concept that is early marriage. The criteria for choosing themes was based on my pre-understanding of the matter rather than the 'entire' holistic picture of what early marriage

is and what its outcomes may be for women's health. Furthermore, I only interviewed women leaving the 50% of population that is equally as valuable. Additionally, I only interviewed health workers at grassroots level leaving out the staff at primary healthcare centres or community healthcare centres in understanding why the PHC closed at 2pm and was not open longer. Thus, my findings and selection of participants was biased.

Participants were selected using a snowballing technique, where we asked the participants if they knew anyone else in similar life situations as them. This meant that we only met a very small section of the community. It is also very difficult to generalise from the short number of interviews as well as the short number of participants. Thus, these findings are only relevant to the eight young married women and eight health workers who participated in this study.

6.2 Recommendations

This study explored the reasons why the practice of early marriage still prevails in Shivgarh despite being illegal as well as the sexual and reproductive health services available to, and accessed by young married women in Shivgarh. This chapter concludes by offering some recommendations for the improvement of the ASHA's intervention on sexual and reproductive health.

Providing recommendations for reducing poverty and changing cultural norms related to early marriage in India would be too pretentious for the purpose of this study. They are very important and very difficult tasks that call for action through a multi-sectoral approach and government involvement. However, what this study can say something about is the type of interventions that target young married women with respect to sexual and reproductive health.

Given that family planning services and provisions for antenatal care exist in this community; the healthcare setting can play a vital role in improving women's situation. The sub-centre level healthcare organisers should consider the following:

- Start their intervention on preparing for pregnancy immediately after marriage rather than waiting until a woman has already become pregnant;

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- Expand the scope of understanding regarding the function of all available contraceptives to community members rather than promoting one irreversible method only;
 - Expand the scope of field visits by engaging in a dialogue with women rather than showering them with information;
 - ASHA to discuss the relevance of information given to the young woman to ensure that she has understood;
 - Discuss the young woman's concerns regarding sex and reproduction rather than presuming that she is fine;
 - Stop presuming that all young married women should get pregnant immediately, and that they do not have a need for contraception as a result of this;
 - Discuss the real importance of hospital delivery rather than simply telling the woman about the monetary incentive;
 - Give adequate sexual health information and advice to all who are sexually active and seek counselling rather than meeting them with moralistic attitudes;
 - Outline the line of responsibility of birth registration to ensure that children are registered; and
 - Consider opening primary healthcare centres till longer so that more women can access delivery and pregnancy services at the local hospitals.

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8. Appendices

This section includes the following appendices:

1. Ethics Approval Norway
2. Ethics Approval India
3. Informed Consent Form- Young Married Women Interviews
4. Informed Consent Form- Health Worker Interviews (Individual and Group)
5. Non- Participant Observations Checklist
6. Interview Guide I: Health Worker Interviews
7. Interview Guide II: Young Married Women Interviews
8. Group Interview Thematic Guide

8.1 #Appendix I: Ethics Approval Norway



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Dato: 05.09.08

Deres ref.:

Vår ref.: S-08439d, 2008/10619

Understanding the Sexual and Reproductive Health Needs of Adolescent brides in Shivgarh, Uttar Pradesh, India- a qualitative study from the perspective of girls, their families and the ASHA-Chain

The Committee considered the application on September 4th 2008. The project has been assessed in accordance with the Norwegian Research Ethics Act of 30 June 2006; see Ministry of Education and Research Regulation of 8 June 2007 and guidelines of 27 June 2007 for the regional committees for medical and health research ethics.

The committee finds that our comments have been answered satisfactorily.

Final decision:

The project is approved

Yours sincerely

Stein A. Evensen (sign.)
Professor dr.med.
Chairman


Ingrid Middelthon
Secretary


Copy:

- Manmeet Kaur, manmeet.kaur@studmed.uio.no

8.2 #Appendix II: Ethics Approval India

Office of the Research Cell
Chhatrapati Shahuji Maharaj Medical University Uttar Pradesh
Lucknow - 226003 (UP) India

Prof. Shally Awasthi
Faculty Incharge



No.: 41856/R.Cell-09
Date: 19/3/2009

To,

Dr. Vishwajeet Kumar,
Director,
John Hopkins Collaborative Projects,
Scientific Convention Center,
CSM Medical University U.P.,
Lucknow


Sub.: Clarification of comments of ethics committee review of Research Proposal entitled
"Qualitative study to understand sexual and reproductive health needs of married adolescents aged between 15-19 in rural Uttar Pradesh" submitted by Dr. Vishwajeet Kumar,
Director, Johns Hopkins Collaborative Projects, Scientific Convention Centre, CSMMU,
Lucknow vide letter no. Nil dated 29-08-2008

Reference: Letter no. : 3661/R. Cell 08, dated 24-10-2008.

Dear Sir,

With reference to the above, clarification of the comments submitted by you vide letter no. Nil dated 19-11-2008, has been approved.

Thanking you,

Yours Sincerely

(Shally Awasthi) 19/03/09
Faculty In-charge

Tel: 2257540, Fax: 2257539
E-mail: research.cell@rediffmail.com

8.3 #Appendix III: Informed Consent Form- Young Married Women Interviews

- The consent was obtained in the local language (Hindi)

My name is Manmeet Kaur and I am pursuing a Master of Philosophy in International Community Health at the University of Oslo. As part of my degree, I am expected to conduct a study. As a woman and as a researcher, I have been very interested in female health issues. Therefore, I am conducting a study trying to understand the sexual and reproductive health needs of young married women in Shivgarh. The purpose of my study is to outline what you think is important for your sexual and reproductive health and outline what kinds of healthcare advice and facilities are available to you. For this, I would like to interview you. As part of my research, I am also going to observe community health workers and talk to them about their experiences.

The interview will last for approximately one hour and I will ask you a few questions. What you tell me will be recorded using a dictaphone. This will be done so that I do not forget everything what you say as I will be typing up the interviews later. After we finish this discussion, only my research assistant and I will have access to the taped and typed interview. The reason for taping, and then typing the interview is for me to correctly grasp what you have said so that I can discuss the issues that you raised with the community health workers. All the information collected from you will be kept in a safe, and only I will have the key to this safe. If you want to take part in this interview, your name will not be used at any time. You will be given a number so that no one is able to identify you. Even if you initially say yes to the interview, you are free to withdraw at any time during or after the interview. Upon completion of data collection, all typed and taped material obtained from you will be destroyed. This is also the case if you withdraw from the interview at any point.

Having said this, the participation is entirely voluntary. This interview will only be used for research purposes, and will not affect your every day life. I would appreciate if you gave me your valuable time, and I will assure you that your opinions are very important to me as a researcher and as a woman. The findings of this study will be made available to you and if you have any questions before, during or after the study, please do not feel free to contact me. This study is also run with the help of the Norwegian Agency of Development Aid

through the Norwegian India Partnership Initiative and Johns Hopkins University, and is partly funded by Save the Children's Research Fund, Norway.

If you have any questions regarding this project, please do not hesitate to call either one or more of the following:

Miss Manmeet Kaur (Tel: 9792191639)

Dr. Vishwajeet Kumar (Tel: 9935689777)

Dr. Bernadette Kumar (Tel: 9871129132)

Consent Statement

I have read the information above (I have heard the information that was read out to me) and I have understood everything. I, hereby, give my full consent by signing (or marking) this form to participate in the study. I have also understood that I can withdraw from the study at any given time and that the information I provide will only be used for research purposes by the researcher.

Signature or mark of the Subject:

.....

Date

Signature of the person obtaining consent

.....

Date.....

Signature of the witness witnessing consent

.....

Date.....

8.4 #Appendix IV: Informed Consent Form Health Worker Interviews

- The Consent will be obtained in the local language (Hindi)

My name is Manmeet Kaur and I am pursuing a Master of Philosophy in International Community Health at the University of Oslo. As part of my degree, I am expected to conduct a study. As a woman and as a researcher, I have been very interested in female health issues. Therefore, I am conducting a study trying to understand the sexual and reproductive health needs of young married women in Shivgarh. The purpose of my study is two-fold: understanding women's sexual and reproductive health issues and to understand the level of healthcare facilities that are available to them. For this, I would like to follow you in the field and invite you to a focus group discussion as well. I will do this as to best understand the types of questions you are asked and the challenges you meet in your work on an every day basis.

The time scope for observation is an entire day, and I would like the opportunity to follow you in the field for an entire day. The focus group discussion, on the other hand, will only last for an hour and a half. During the observations, I will take notes from time to time so as not to forget the types of interactions you have with the women. The focus group discussions will be recorded using a dictaphone. This will be done so that I do not forget everything what you say as I will be typing up the discussions later. After we finish this discussion, only my research assistant and I will have access to the taped and typed material. The reason for taping, and then typing is for me to correctly grasp what you have said so that I can discuss some of the issues that you raise with the women in the community.

All the information collected from you will be kept in a safe, and only I will have the key to this safe. If you want to take part in the observation and focus group discussion, your name will not be used at any time. You will be given a number so that no one is able to identify you. Even if you initially say yes to the taking part in this study, you are free to withdraw at any time during or after the observation/focus group discussion. Upon completion of data collection, all typed and taped material obtained from you will be destroyed. This is also the case if you withdraw from the study at any point.

Having said this, the participation is entirely voluntary. This interview will only be used for research purposes, and will not affect your every day life. I would appreciate if you gave me your valuable time, and I will assure you that your opinions are very important to me as a researcher and as a woman. The findings of this study will be made available to you and if you have any questions before, during or after the study, please do not feel free to contact me. This study is also run with the help of the Norwegian Agency of Development Aid through the Norwegian India Partnership Initiative and Johns Hopkins University, and is partly funded by Save the Children's Research Fund, Norway.

If you have any questions regarding this study, please do not hesitate to contact either one or more of the following:

Miss Manmeet Kaur (Tel: 9792191939)

Dr. Vishwajeet Kumar (Tel: 9935689777)

Dr. Bernadette Kumar (Tel: 9871129132)

Consent Statement

I have read the information above (I have heard the information that was read out to me) and I have understood everything. I, hereby, give my full consent by signing (or marking) this form to participate in the study. I have also understood that I can withdraw from the study at any given time and that the information I provide will only be used for research purposes by the researcher.

Signature or mark of the Subject:

.....

Date

Signature of the person obtaining consent

.....

Date.....

Signature of the witness witnessing consent

.....

Date.....

8.5 #Appendix V: Non-Participant Observations Checklist

Health Workers in the Field:

- How do the community health workers contact women?
- What processes are involved in identifying the population where they work?
- What kind of transport do they use in getting from A to B?
- What kinds of equipment do they carry during their field visits?
- How do they make themselves visible in the communities where they work?
- What do they normally wear?
- How do they organise their meetings?
- What is the physical setting of this meeting?
- Who is involved in it?
- Where do the health workers sit and how do they talk to the involved parties?
- Make a note of their tone of voice, facial expressions, seating plan when talking to community members.
- What are the main topics covered during such sessions?
- How much time do they give to each individual?
- How much time do they take to explain what they have said?
- How do they explain technical terms?
- Do they sound and look enthusiastic in talking about health issues?
- Do they need to convince women to follow certain health behaviours? If yes, how do they do this?
- Do various types of community health workers (ASHA; AWW; ANM) work together? If yes, how? If no, what is their visibility in the community?
- Are there certain things these community health workers find easier to talk about? If yes, which? If no, which?
- Are there power structures among different health workers? If yes, which and how?
- Are there power structures between health workers and community members? If yes, describe.

Young Married Women:

- Note appearance with respect to weight – Do these women look visibly thin or fat?
- Note facial expressions and emotional state when expressing something.
- Visible age – can I place them in adolescence or are they adults?

- Note down how they talk to the health workers?
- What is their 'space' in the house?
- How do they manage this space?
- If they are engaged in a specific activity, what is it?
- What is their communication between other family members during the visit?
- What does their house look like?
- Where is their spouse?
- How and where do we sit during our conversations and why?

8.6 #Appendix VI: Health Worker Interview Guide

1. Training: (Ask these questions as an entry point to questions on sexual and reproductive health)

- Where did you receive your training?
- How long was this training?
- What did it involve?
- Did you receive any practical training?
- How useful was your training?
- What was the most important thing you learned there?
- How do you identify if someone has a problem?
- How does this training help you in your work?
- Who is responsible for this training?

Work Schedule:

- What is your daily work time-table? OR
- How many times a week do you go to the field?
- How many households are there in your field?
- How do you get to these households?
- How do you make time to go around all the households?
- How does your being a housewife affect your daily schedule?
- What are the types of things you talk about in the field?
- What do you think is important to tell the people in the community?
- What do you tell the women?
- How do you find out if someone is pregnant?
- What types of things do you tell the married women who are not pregnant?
- What is the most important advice you give to these women?

Questions on Sexual and Reproductive Health:

- How old are the newly weds in your community?
- People tell me that they do not know their age. What do you think about that?
- Who is responsible for birth registration in this village?
- Why do you think birth registration is important?
- Let us say that you meet a woman, and she does not want your help. What do you do?

- How do you handle this situation?
- You told me that you received training on family planning. How does that work in your work-life?
- What kind of advice do you give to the women who want to plan for the family?
- What do you tell younger women?
- Which methods are good and which are bad?
- Why do you think these are good?
- Why do you think these are bad?
- So, why should a woman get sterilised?
- Are there any alternatives to this?
- What do you tell women who are in sexual relationships but are not married?
- What types of advice would you give them?
- Why would you give them this advice?
- How many such women are there in your community?

Decisions related to sexual and reproductive health:

- So, who is important when you are telling women about health issues?
- Can the woman make these decisions herself?
- Who influences her, you think?
- Why do these people influence her?
- What is important for you to tell these people?
- Do they always agree with you?
- What do you do if they do not agree?

*Modify questions if some topics become more important than others.

8.7 #Appendix VII: Young married women interview guide

Age:

- How old are you?
- Do you have a birth certificate?
- If you were to guess, how old do you think you were?
- Why would you think that you are this old?
- *Use Age Autopsy to determine the age of the participants in case if they do not know.

Marriage:

- So, tell me about the time you got married. How did that happen?
- Whose decision was it?
- Did you know the guy you were getting married to?
- Tell me how your life was before you got married?
- What is new now?
- Why is it new?
- What do you think is important in being married?
- So, what responsibilities are most important?
- Why are they important?

Puberty: (Coincide with questions on marriage)

- So what happens when you have your bal dulahi?
- Do you tell anyone?
- Did you know what it was when you had it the first time?
- Did anything change in your life then?
- If yes, what? How? How long for?
- What did your parents do when you told them about this?

Sex:

- So you were telling me about being married and sleeping next to your husband. Tell me about that. What is it like?
- How often do you have sex?
- Who initiates it? How does it happen?
- Do you like it?
- Is it important to you? If yes, why? If no, why not?

- How was it like the first time around?
- What did you feel?
- Did you tell anyone?
- So who makes the decision to have sex?
- Tell me more about what is expected of you when you are having sex.
- What do you think about having babies?
- So, who makes the decision of having babies?

Family Planning:

- So do you use anything to get pregnant?
- Do you use anything to avoid getting pregnant?
- If yes, why do you use this?
- If not, why do you not want to use anything?
- What do you think your friends use?
- Is it cheap to get these things here?
- How can one get these?
- What is good for a woman to use?
- What is bad to use? Why?
- So tell me about a time when you have used something? (If used)
- If not – tell me about how you prevent getting pregnant.
- Do you talk to the health didi about this?
- Do they tell you anything?
- Why do you think they tell you this?

Antenatal care:

- So you were telling me that, when you got pregnant, you did not talk to ASHA. Tell me about that.
- So where did you deliver?
- Why did you deliver there?
- In case – someone is not pregnant: How many children do you want to have?
- Have you talked to any health didi about this?
- *Use participants' responses to develop further on this.

8.8 #Appendix VIII: Group Interview Themes

Themes to discuss (build on from health worker and young women's interviews):

- Training – what aspects of their training is important?
- Why? What is the most important message?
- Work life – what difficulties do they face in their jobs?
- The money issue – why is money an issue? What is going on with the pay cheques?
- Pre-marital sex – who engages in these practices and why?
- What do the health workers think about them?
- What should they do?
- What about abortions? Safe or unsafe?
- Sex in marriage – what is important?
- Which advice?
- Early marriage – how many people get married early?
- Why do they do that? What can be done?
- Is it bad/ good?
- Family planning – which methods are good? Why?
- So why sterilisation but not vasectomy?
- Why not other things?
- Hospital delivery- So what is important in delivering at the hospital?

